DOCUMENT RESUME

ED 474 734 CG 032 299

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TITLE	Building Emergency Contraception Awareness among Adolescents. A Toolkit for Schools and Community-Based Organizations.
INSTITUTION	Academy for Educational Development, Inc., New York, NY.
PUB DATE	2003-00-00
NOTE	144p.
AVAILABLE FROM	Academy for Educational Development, 100 Fifth Ave., New York, NY 10011. Tel: 212-243-1110; Fax: 212-627-0407; e-mail: adminny@aed.org; Web site: www.aed.org. For full text: http://scs.aed.org/ECtoolkit3283.pdf.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF01/PC06 Plus Postage.
DESCRIPTORS	*Adolescents; *Community Organizations; *Contraception; Females; Health Education; Program Evaluation; *Resources; *School Health Services; Sexuality

ABSTRACT

This toolkit presents emergency contraception (EC) as a method to help adolescent women avoid pregnancy and abortion after unprotected sexual intercourse. The sections of this toolkit are designed to help increase your knowledge of EC and stay up to date. They provide suggestions for increasing EC awareness in the workplace, whether it is a school district, a school, a school-based or school-linked health center, or a community-based organization (CBO). The toolkit is divided into six sections. Section 1 provides basic information about EC pills--what they are, how they work, their efficacy and safety, where to obtain them, and the cost. Section 2 makes the case that teens should know about EC, prepares adults to increase access and awareness among teens, as well as their own peers, and identifies resources for keeping current on the issues. Section 3 explains why pregnancy prevention matters to schools and how to increase EC awareness in schools and respond to questions that may arise in the school context. Section 4 addresses EC issues specific to school-based health centers, including activities to increase EC awareness among clinic and school staff. Section 5 describes steps that CBOs can take to increase EC awareness among adults who work with teens, and teens themselves, both in partnership with schools and in their own community programs. And section 6 provides a brief overview of evaluation for both schools and CBOs and suggests some basic, low-cost program evaluation strategies. The toolbox contains tools to build EC awareness, including sample letters, articles, forms, protocols, and instruments. (GCP)

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EMERGENCY CONTRACEPTION

A Toolkit

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Building EMERGENCY CONTRACEPTION Awareness Among Adolescents

A Toolkit

For SCHOOLS and COMMUNITY-BASED ORGANIZATIONS

ACADEMY FOR EDUCATIONAL DEVELOPMENT

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2003

TABLE OF CONTENTS

Acknowledgments

Introduction 1

Section 1 Emergency Contraception Facts 5

Section 2 Emergency Contraception and Teens 17

Section 3 Emergency Contraception and Schools 35

Section 4 Emergency Contraception and School-Based Health Centers 53

Section 5 Emergency Contraception and Community-Based Organizations 61

Section 6 Measuring Progress 75

Toolbox

1. Emergency Contraceptive Pills
2. Fact Sheets about EC and Other Sources of Materials
3. Training Resources
4. Sample EC Lessons for Teens
5. Sample Newsletter Articles about EC
6. Resources for School-based Health Centers
7. Management Information and Evaluation Tools
8. The New York Story: A Case Study of *You Can't Teach What You Don't Know*

ACKNOWLEDGMENTS

This toolkit could not have been accomplished without the assistance of many knowledgeable and generous professionals who helped in a variety of ways. First of all, we would like to thank the David and Lucile Packard Foundation, as well as the General Service Foundation and the Child Welfare Fund for their generous support. In addition, we would like to acknowledge previous funders of AED's emergency contraception and adolescents work—the Open Society Institute, the John Merck Fund, and the Turner Foundation. The EC projects they funded paved the way for our current work with schools and community-based organizations.

Several people made significant contributions to this toolkit: We are particularly grateful to Alwyn Cohall and Renee Cohall, both at the Mailman School of Public Health, Columbia University. In addition to their expertise in adolescent reproductive health that benefitted earlier collaborations with AED on EC, the Cohalls played a lead role in developing teen-friendly EC materials and created the teen-training slide presentation in the toolbox. Protocols for school-based health centers were provided by Lorraine Tiezzi and Pam Haller, Center for Community Health and Education Program, Mailman School of Public Health; and Angela Diaz, Mount Sinai Adolescent Health Center, New York City. We also thank Barbara Sheaffer, Pennsylvania Coalition Against Rape for her suggestions about the section on suspected rape and sexual abuse. We drew useful information from the many websites cited but would particularly like to acknowledge the national emergency contraception website and the websites of the Center for Reproductive Law and Policy and Reproductive Health Technologies Project.

AED also expresses sincere appreciation to the many people who reviewed the toolkit and made helpful suggestions. They include Laura Davis and Tamara Moss, Advocates for Youth, Washington, DC; Pat Maloney and Ellen Krug, Teen Choice Institute, Inwood House, New York City; from Population Services International, John Beleutz and Nan Lewicky, Watsonville, CA, and Abi Brown, Sacramento, CA; Allen James, HIV/AIDS TA Project, New York City; Cathy Feaster and Angelia Zinsli, Municipality of Anchorage Reproductive Health Clinic, AK; Wendy Bernal, Girls Incorporated of New York City; Sue Lapp, School-based Health Centers, Campbell, CA; Frances Barrios and Myrna Oliver, Planned Parenthood Mar Monte, San Jose, CA; Jan Marquard, School Health Services, Northeast Valley Health Corporation, San Fernando, CA; Kate Hartzell, Delta School Education Program, Cabrillo College, Aptos, CA; Joyce Schornick, San Jose Unified School District, San Jose, CA; Mary Jacobs, Family Learning Center, Foothill High School, San Jose, CA; Rick Loya, Los Angeles Unified School District; Eileen Donnelly, Aricelli Castillo, and Lupe Rocha, Salud Para La Gente, Watsonville, CA; and Theresa Ontiveros, Clinica Mariposa Planned Parenthood, Watsonville, CA.

Finally, special appreciation goes to the AED staff and consultants who helped prepare this toolkit: Nancy Shanfeld for her input to the toolkit and for recruiting and obtaining feedback from most of the California reviewers; Elayne Archer and Rebecca McBride for editing the toolkit; Noemi Corujo for her administrative assistance; and Lynne Yeamans, the graphic designer.

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New York City
2003

Introduction

Working with adolescents to help them prevent unintended pregnancies is challenging. To date, we have relied on the tools at our disposal to help youth establish goals for their futures; understand the immediate and long-term consequences of their behaviors; and consider sex in the context of healthy relationships. We have also promoted abstinence and informed teens about contraception, especially condoms, helping them gain the skills to use them consistently. Now we have another tool to use in our work—**emergency contraception (EC)**—a method to help women avoid pregnancy *and* abortion *after* unprotected sexual intercourse.

The good news is that EC is safe and legal. It is FDA-approved and has been used in the United States and Europe for decades. The not-so-good news is that many teachers, counselors, and health professionals who work with teenagers have either never heard of EC or vaguely know about it as the misleadingly named "morning-after pill." They do not know that EC pills (ECPs) cannot disrupt an established pregnancy, and they mistake EC for mifepristone or RU 486, the "French abortion pill." Anyone unfamiliar with EC, or with only a partial idea of how it works, is probably not going to tell teenagers about it. After all, you can't teach what you don't know. The purpose of this toolkit is to inform you about EC and increase your comfort in telling others about it.

SOMETHING NEW? OH NO!

The authors of this toolkit have years of experience in the field of adolescent reproductive health and know that people who work with adolescents are hard-working and dedicated. The last thing they need is to take on a new issue. That's why we stress that EC is simply a new tool for an old problem. In fact, much of what you read in these pages is going to sound familiar. We're not asking you to expand your job. We're helping you do the same job better.

To begin with, there is nothing really new about the chemistry of the EC pill; it has the same ingredients as oral contraceptives. In fact, many emergency room personnel have been cutting up packages of oral contraceptives for 40 years to give to sexual assault survivors. So you already know what EC pills contain, and that is a big step.

There are other steps, but that is what this toolkit will do: it will describe these steps and answer many questions. After reading the toolkit, not only will you know about EC, but, just as important, you will be able to teach the people and organizations you work with, and then, most important, you will be able to help the teenagers who depend on you for accurate information and guidance.

IT CAN BE DONE!

For the past two years, with support from the David and Lucile Packard Foundation, the General Service Foundation, and the Child Welfare Fund, the Academy for Educational Development (AED) has been working in New York City public high schools and community-based organizations (CBOs) that partner with schools. To date, the project, *You Can't Teach What You Don't Know*, has increased EC awareness in over 50% of the city's high schools by training the adults responsible for health education; prevention of pregnancy, HIV/STDs, and substance abuse; guidance; and youth-development programs. In turn, these people have used this new information to help teens. They have disseminated information schoolwide through health fairs and health education classes, counseled students who ask about EC, and displayed posters and brochures in nurses' offices, school-based health centers, and resource rooms.

The sections of this toolkit are designed to help increase your knowledge of EC and stay up to date. They provide suggestions for increasing EC awareness in the workplace, whether it is a school district, a school, a school-based or school-linked health center, or a CBO. The six sections are described below.

Section 1: Emergency Contraception Facts

Provides basic information about ECPs—what they are, how they work, their efficacy and safety, where to obtain them, and the cost.

Section 2: Emergency Contraception and Teens

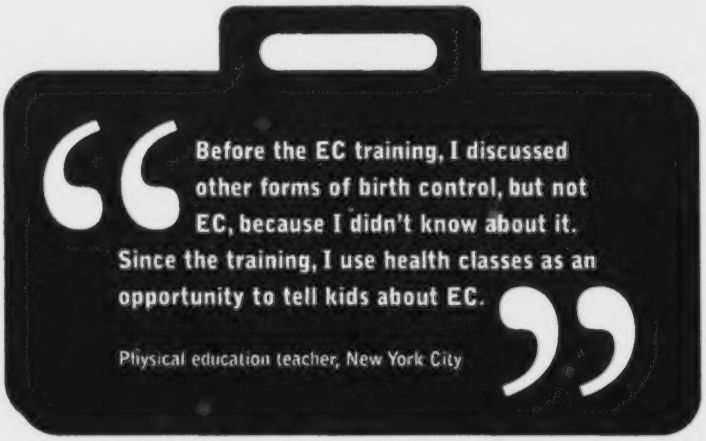
Makes the case that teens should know about EC, prepares adults to increase access and awareness among teens, as well as their own peers, and identifies resources for keeping current on the issues.

Section 3: Emergency Contraception and Schools

Explains why pregnancy prevention matters to schools and how to increase EC awareness in schools and respond to questions that may arise in the school context.

Section 4: Emergency Contraception and School-Based Health Centers

Addresses EC issues specific to school-based health centers, including activities to increase EC awareness among clinic and school staff.


"Before the EC training, I discussed other forms of birth control, but not EC, because I didn't know about it. Since the training, I use health classes as an opportunity to tell kids about EC."
Physical education teacher, New York City

Section 5: Emergency Contraception and Community-Based Organizations

Describes steps that CBOs can take to increase EC awareness among adults who work with teens, and teens themselves, both in partnership with schools and in their own community programs.

Section 6: Measuring Progress

Provides a brief overview of evaluation for both schools and CBOs and suggests some basic, low-cost program evaluation strategies.

Toolbox

Contains tools to build EC awareness, including sample letters, articles, forms, protocols, and instruments. Everything in this section can be reproduced.

Note: Sections 1, 2, and 6 are intended for all readers of this toolkit. However, there is some inevitable repetition in sections 3, 4, and 5. We assume that busy school, health center, and CBO staff will read only that section geared to their workplace.

SOUNDS INTERESTING, BUT DO I REALLY NEED TO KNOW ABOUT THIS?

If we haven't already convinced you of EC's importance, consider this: the word is out. Once a well-kept secret, EC is finally becoming known to women of all ages—including teenagers. There are ads in popular magazines and on buses and subways. EC information is easily accessible on the World Wide Web. Information (and misinformation) is spreading, so it's important to know the facts.

For example, in some states, women can now get ECPs directly from pharmacists without first needing a doctor's prescription. Other states are moving in this direction as well. This is an important means of access because time is of the essence when it comes to EC. The sooner a young woman gets EC, the greater her chances of preventing a pregnancy. As laws change—as they do in this dynamic field of reproductive health—it's important to know how to get the latest information. That's what we hope to provide here: resources for the latest, and best, information.

Throughout this report, highlighted boxes contain facts, tips, resources, quotes, and stories from the field to help increase awareness about EC among adolescents and adults in your schools and communities.

Section

Emergency Contraception Facts

Provides basic information about emergency contraceptive pills—what they are, how they work, their efficacy and safety, where to obtain them, and the cost.

Section 1 Emergency Contraception Facts

This section contains basic information about emergency contraceptive pills, as well as resources for obtaining more detailed EC information. (The toolbox also contains EC resources and sample fact sheets to inform teens and adults about basic EC information[1]).

WHAT ARE EMERGENCY CONTRACEPTIVE PILLS?

ECPs are used to *prevent* pregnancy *after* unprotected sex. These pills reduce the chances of pregnancy if taken within 120 hours after unprotected vaginal intercourse. Although ECPs are sometimes known as the "morning-after pill," it is not necessary to wait until the morning after, and they can be taken up to 5 days after unprotected sex.[2] The sooner they are taken, the more effective they will be.

An intrauterine device (IUD) can also be used for emergency contraception if inserted 5 to 7 days after unprotected sexual intercourse. This method is very effective for preventing pregnancy and can serve as an ongoing form of contraception. This toolkit only provides information about ECPs because IUDs are not generally prescribed for teens.

There are many situations when ECPs can be helpful as a backup method for unprotected sex. For example when:

* **Pregnancy was not wanted but no method of birth control protection was used.**
* **A condom slipped or broke.**
* **Birth control pills were skipped more than 2 days in a row.**
* **Sex was forced.**

ECPs contain the same hormones (estrogen and/or progestin) as ordinary birth control pills. Currently two products are packaged and labeled specifically for emergency use in the U.S.—Plan B® and PREVEN®. In addition, the FDA has approved the use of 11 brands of birth control pills for emergency contraceptive use (see Toolbox-1). The doses vary, depending on the brand.

In most states ECPs must be obtained with a prescription from a licensed health care practitioner. In Alaska, California, New Mexico, and Washington, some pharmacists can provide EC pills directly. In these states, a visit to a doctor to obtain the prescription is not needed. Some health care providers (e.g., physicians with whom you already have a relationship or Planned Parenthood affiliates participating in the Dial EC program) will phone an EC prescription to a local pharmacist without a visit (see Toolbox-1).

HOW DO YOU TAKE ECPS?

Most ECPs require two doses, taken 12 hours apart. The first dose should be taken as soon after unprotected sex as possible. The second dose should be taken 12 hours later. A woman taking ECPs should choose a time that increases the chances of her taking the second dose. For example, if the first dose is taken at 3 P.M., the next dose would be scheduled for 3 A.M. It may be more convenient to take the doses at 7 P.M. and 7 A.M. These adjustments can be made as long as the first dose is taken within 72 hours.

According to the EC website, only one dose of Plan B® (2 pills), taken as soon as possible, is needed to prevent pregnancy.

HOW DO ECPS WORK?

ECPs work by delaying the release of an egg from the ovary or inhibiting transport of the egg or sperm through the fallopian tubes, thereby preventing fertilization. If the egg is fertilized, ECPs inhibit a fertilized egg from implanting in the uterine wall. The way that ECPs work depends on where a woman is in her menstrual cycle when she takes them.

ECPs will not end an established pregnancy. Once an egg is released from the ovary, it takes 12 to 24 hours to be fertilized. It then takes another 5 to 7 days for the fertilized egg to become implanted in the uterus.[3] Organizations of medical experts, such as the National Institutes of Health and the American College of Obstetricians and Gynecologists, consider implantation the beginning of pregnancy. Using ECPs within 5 days of unprotected sex cannot result in abortion because pregnancy has not begun. And again, if ECPs are taken after implantation, the pregnancy will not be interrupted.

Sometimes people confuse ECPs with mifepristone (the pill that causes medical abortion, sometimes also known as RU 486). They are completely different drugs. Mifepristone is used to terminate a confirmed pregnancy; it can be taken up to 7 weeks of pregnancy.[5]

Fact

ECPS DO NOT CAUSE ABORTION.

EC has the potential to avert half of all unintended pregnancies. Because almost half of all unintended pregnancies in the United States end in abortion, EC could therefore eliminate half of all abortions.[4]

DO ECPS HAVE SIDE EFFECTS?

Most women take ECPs without any problem, but some experience side effects that usually last less than 24 hours. About half of women who take the combined ECPs (PREVEN® or birth control pills with estrogen and progestin) experience nausea, and 20% vomit. Progestin-only regimens (Plan B®) are associated with nausea in 23% of women, and 6% of these women are sick to their stomach.

Women who start to vomit *within* 2 *hours* of taking the first dose should take another dose as soon as possible and call their provider immediately for a prescription refill.

Tip

ANTINAUSEA MEDICINE, TAKEN IN ADVANCE, CAN REDUCE THE MAIN SIDE EFFECTS OF ECPS.

Other side effects such as breast tenderness, fatigue, headache, dizziness, and irregular menses are temporary and do not usually require follow-up with a health care provider.[6] And remember, the side effects of pregnancy and abortion can be much worse!

The second dose should be taken 12 hours after the replacement dose. If vomiting starts 2 *hours after* taking a dose, the medication is already working, and no replacement dose is necessary.

Taking ECPs with food or milk may help reduce nausea. Use of an antinausea medicine (available over the counter or by prescription)—dymenhydrinate (Dramamine), cyclizine hydrochloride (Marzine), diphendramine (Benadryl), or hydroxyzine (Atarax)—30 to 60 minutes before taking ECPs also may reduce nausea.

ARE ECPS SAFE?

Since the 1970s, thousands of women throughout the world have safely used ECPs to avoid unintended pregnancy. No serious side effects or deaths have been reported.[7] There are no known medical reasons that a woman cannot take ECPs. In fact, women who cannot use birth control pills as their regular method (e.g., because of medical problems such as hypertension or diabetes) can take ECPs because of the short time-period of use and because the hormones do not accumulate in the body. If a woman is already pregnant, she should not take ECPs because they are for pregnancy prevention only. However, if a woman happens to take ECPs when she is already pregnant, the fetus will not be harmed.

ARE ECPS EFFECTIVE?

The effectiveness of ECPs depends on the product and how soon after unprotected sex they are taken. ECP products containing a combination of estrogen and progestin, such as PREVEN® and 10 of the 11 birth control

Fact

ECPs taken within 72 hours of unprotected sex reduce the risk of pregnancy by 75% to 89%.

pills approved by the FDA for emergency use, reduce the risk of pregnancy by 75% over 3 days. Plan B®, a product containing progestin-only, reduces the risk of pregnancy by 89%.

The sooner ECPs are taken after unprotected sex, the more effective they will be. For example, if Plan B® is taken *within 24 hours*, it can prevent 95% of expected pregnancies.[8] Preliminary evidence from recent research indicates that ECPs continue to be effective 4 or 5 days after unprotected intercourse.[9] Because taking ECPs may reduce the chance of pregnancy and are not harmful, most practitioners prescribe ECPs up to 120 hours (5 days) after unprotected intercourse.

If a woman who has taken ECPs does not have a period within 3 weeks or if she has other symptoms of pregnancy, she should see her health care provider. Even if a woman has her period within 3 weeks after taking ECPs, it is recommended that she see her health care provider for a comprehensive reproductive health exam and STD/HIV testing, and to discuss correct and consistent contraceptive use.

WHY ARE ECPS JUST FOR "EMERGENCIES"?

Other forms of birth control are more effective at preventing pregnancy. Also, ECPs do not protect against sexually transmitted infections, including HIV/AIDS.

Tip

CONDOM USE AND ECPS

Remind teens to use condoms every time they have sex. Condom-use messages make a difference: rates of condom use in the adolescent population increased significantly over the last decade. In Ethiopia, ECPs and condoms are packaged together to reinforce the message that condoms should be used even though ECPs are available.

WHERE CAN WOMEN GET ECPS?

Women can obtain ECPs from health care practitioners (directly and by telephone), pharmacists, and on the World Wide Web.

Health Care Practitioners

A health care practitioner must prescribe ECPs in most states. If a woman does not already have a relationship with a health care provider, she can contact the national EC hotline at **1-888-NOT-2-LATE** (English) or **1-866-EN-TRES-DIAS** (Spanish), or go to **www.not-2-late.com** to get a list of providers in her community. In many larger communities, there are health centers specifically for adolescents. Family planning and Planned Parenthood clinics also often have adolescent-oriented services and fees based on ability to pay. Women can find the nearest Planned Parenthood by calling **1-800-230-PLAN** or visiting **www.plannedparenthood.org/ec**.

Pharmacists

In Alaska, California, New Mexico, and Washington women can obtain ECPs directly from participating pharmacists without first visiting a medical practitioner. More states are developing coalitions to support the legislation needed for similar pharmacy-access initiatives. In order to participate, pharmacists must complete a training program and then work in collaboration with a prescriber (e.g., physician or nurse practitioner) following a specific protocol. Under this protocol, pharmacists are required to ask consumers several questions in a confidential setting and give them a fact sheet. They may ask consumers to sign a consent form, and there may be a separate charge for the consultation.

Resources

HOW TO FIND PARTICIPATING PHARMACISTS

All women can call 1-888-NOT-2-LATE (English), 1-866-EN-TRES-DIAS (Spanish), or go to www.not-2-late.com. In California, participating pharmacists are listed on the EC Pharmacy Program website, www.EC-Help.org. Sometimes the best way to find out if a local pharmacist participates in the program is to ask him/her directly. This way, you will have the most up-to-date information, and the pharmacist will know that consumers are interested.

EC by Telephone

As of March 2002, 47 Planned Parenthood affiliates offer EC over the telephone (see Toolbox-1). Women (even those who may not have used the clinic before) who call the local affiliate are screened over the telephone; if approved, the affiliate health care provider calls the prescription in to a pharmacist. These clinics will probably recommend that the woman make a follow-up visit for HIV/STD testing and more reliable contraceptive methods.

EC on the Internet

Currently four Planned Parenthood affiliates with websites will help women access ECPs quickly without a medical examination. The woman must complete a confidential questionnaire, and, if eligible, a practitioner will call a prescription in to a pharmacy of the woman's choice. There is a nonrefundable assessment fee ($25-$40), and the woman must pay for the pills. These on-line services may not be available when the clinics are closed.

* **Planned Parenthood of Greater Indiana**
  www.ppin.org/ecaccess
  restricted to women who are Indiana residents and 18 years of age or older.

* **Planned Parenthood of Chicago Area**
  www.ppca.org
  Illinois residents only.

* **Planned Parenthood of Georgia**
  www.ecconnection.org
  Georgia residents only.

* **Planned Parenthood of Columbia/ Willamette**
  www.ppcw.org
  Oregon and Washington residents only.

Over the Counter

Well, not yet. In February 2001, the Center for Reproductive Law and Policy petitioned the FDA to make EC an over-the-counter product. The manufacturer of Plan B® is in the process of preparing an application to the FDA to obtain over-the-counter status. It is unclear how long the FDA will take to act on the petition. The American College of Obstetricians and Gynecologists and many other professional organizations support over-the-counter availability of EC.[10]

Did You Know?

EC is available over-the-counter in Norway and Sweden. It is available directly from a pharmacist in 25 other countries in Europe, Asia, Africa, and the Middle East.[11]

HOW MUCH DO ECPS COST?

It depends. The average retail cost of the pills is $20-$25, and the cost of an office visit can vary widely. As mentioned above, Planned Parenthood and other family planning clinics typically reduce their fees for teens and others who cannot afford the regular fee. Costs for office visits can be avoided if the provider is willing to call a prescription in to a pharmacy. Costs of pills and visits may also be covered by health insurance.

Some states have programs that pay for ECPs for women who meet eligibility requirements. For example, California residents can use Family PACT, a program of the Office of Family Planning, which provides comprehensive family planning services to low-income women and men who have no health insurance or who are under-insured. Family PACT also provides care for women who are unable to obtain confidential care with their existing health insurer. Among the comprehensive services provided are education, counseling, and emergency contraception.

ARE ECPS AVAILABLE IN ADVANCE?

Having a written prescription or pills on hand will help ensure that a teen can use ECPs in a timely manner if the need arises. Many health care providers will give patients an advance prescription for ECPs; however, it is often up to the patient to ask for one during a medical visit. Having a prescription in advance is one way to eliminate the cost of an office visit for ECPs and makes it much easier to start the regimen soon after unprotected sex. Teens should be cautioned to check the expiration date on the package before taking the pills.

Resources

FAMILY PACT

For more information about California's Family PACT program, including benefits and services, client eligibility and enrollment, and providers, go to www.dhs.cahwnet.gov/pcfh/ofp/famPACT, or call the OFFICE OF FAMILY PLANNING at 916-654-0357.

Resources

THE ALAN GUTTMACHER INSTITUTE website provides information on specific laws governing minors' rights to medical care in each state: www.agi-usa.org.

PHYSICIANS FOR REPRODUCTIVE HEALTH AND CHOICE has developed brochures with information about minors' rights to reproductive health care in New York, New Jersey, Pennsylvania, and Georgia. (Brochures for Maine and Massachusetts are forthcoming.) Go to www.prch.org or call 646-366-1890.

THE ACLU REPRODUCTIVE FREEDOM PROJECT offers information and free fact sheets on parental involvement in minors' reproductive health care. They can be ordered in bulk at www.aclu.org/ReproductiveRights/ReproductiveRightsMain.cfm or call 212-549-2633 to obtain both national- and state-level information.

CAN TEENAGERS OBTAIN ECPS WITHOUT PARENTAL NOTICE OR CONSENT?

Clinics participating in the Federal Title X Family Planning Program are required to provide confidential services to teens. In other settings, state laws determine whether medical practitioners can provide EC to minors without notifying parents or obtaining their consent. In some states like New York, a minor can give informed consent and receive confidential services for all family planning care.[12] To find out about laws in your state, contact the Alan Guttmacher Institute or the ACLU Reproductive Freedom Project. Other state or local resources might include the state chapter of the American Civil Liberties Union, reproductive health advocacy organizations, the state health department, or local Planned Parenthood affiliates.

Regardless of the law, there may be health care providers (or clinic policies) requiring parental consent to prescribe ECPs to minors. If this is the case, determine whether confidentiality is an issue; if it is, suggest that the teen consult a provider who can offer confidential care and give her the contact information.

FOOTNOTES

[1] The national emergency contraception telephone hotline is 888-NOT-2-LATE (English), 866-EN-TRES-DIAS (Spanish), and the website is www.not-2-late.com. Three excellent EC print resources are Consortium on Emergency Contraception, *What is Emergency Contraception?*, downloadable at http://cecinfo.org//html/fea-what-is-ec.htm; Hatcher RA, Trussell J, Stewart F, Howells S, Russell C, Kowal D, *Emergency Contraception: The Nation's Best-Kept Secret*. Atlanta: Bridging the Gap Communications, Inc., 1995; and "Fact Sheet: Emergency Contraception"—www.plannedparenthood.org/library/BIRTHCONTROL/EC.html. The Association for Reproductive Health Professionals—www.arhp.org—is also a reliable information source.

[2] Recent research suggests that ECPs are effective 5 days after unprotected sex and therefore worth prescribing up to this point. A small study in Canada found that the effectiveness rate ranged from 72%-87% for a group of 169 women who took ECPs 72-120 hours after unprotected sex. See Rodrigues I, Grou F, Joly J, "Effectiveness of ECPs between 72 and 120 hours after unprotected sexual intercourse," *American Journal of Obstetrics and Gynecology*, 2001, 184:531-7.

[3] Hatcher RA, et al, 1995 (see note 1).

[4] Hatcher RA, et al, 1995 (see note 1), p. 32.

[5] U.S. Food and Drug Administration, Center for Drug Evaluation and Research, *Mifepristone Questions and Answers*, www.fda.gov/cder/drug/infopage/mifepristone/mifepristone-qa.htm.

[6] The not-2-late website: http://ec.princeton.edu/questions/sideeffects.html.

[7] Van Look P and Stewart F, "Emergency contraception," in Hatcher RA et al., eds., *Contraceptive Technology*, 17th edition, New York: Ardent Media, 1998, 277-295.

[8] "Consumer's Guide to Plan B," http://www.go2planb.com/consumer_guide.

[9] The not-2-late website: http://ec.princeton.edu/questions/ectime.html.

[10] American College of Obstetricians and Gynecologists. Statement of the American College of Obstetricians and Gynecologists supporting the availability of over-the-counter emergency contraception, news release, 2/14/01.

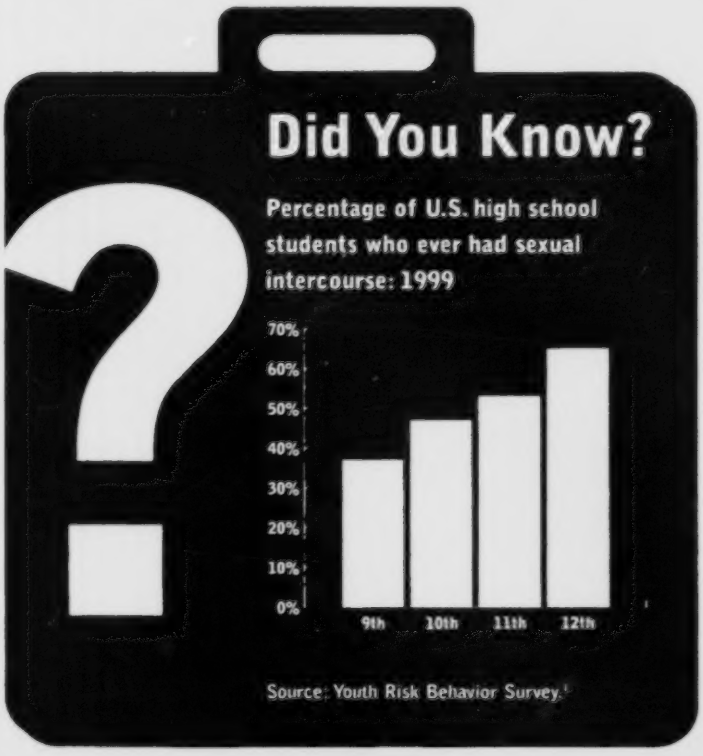
[11] American Society for Emergency Contraception, Dedicated ECPs Worldwide, list as of September 28, 2002.

[12] Mount Sinai Adolescent Health Center, New York Civil Liberties Union Reproductive Rights Project, and Physicians for Reproductive Health and Choice, *Minors' Rights to Confidential Reproductive Health Care in New York State*, January 2000.

Section 2

Emergency Contraception & Teens

Whether you work in a school, CBO, or another setting, this section of the toolkit can help make the case for increasing EC awareness and access for teens. This section also addresses the special concerns of adolescents to help professionals respond to their reproductive health needs. The resources described here and included in the toolbox can be reproduced for use in meetings or training sessions about EC and teens. (See sections 3, 4, and 5 for specific outreach strategies in schools, school-based health centers, and CBOs). This section includes:



* **Who Cares?**
  Explains why teenagers should know about EC.

* **Preparing Adults to Inform Teens About EC**
  Outlines what adults can do to help inform teens about EC, including key EC messages for teens.

* **EC Issues Specific to Teens**
  Includes consent and confidentiality, talking to parents, rape and sexual abuse, cost, males, stresses, and access to ongoing contraception.

* **Staying Up to Date on the Issues**
  Includes medical, legal, and research issues, and resources to keep you up to date.

* **Guide to Teen-Friendly EC Materials and Information**
  Describes free materials to use with teens and resources for finding more.

* **Responses to Difficult Questions About EC and Teenagers**
  Answers questions you may have or may encounter from other adults.

WHO CARES? WHY TEENAGERS SHOULD KNOW ABOUT EC

Every year in the U.S., approximately 900,000 teenage women become pregnant—10% of all girls age 15-19 and 19% of those who are sexually active.[2,3] Nearly 40% of young women in the U.S. become pregnant before the age of 20.[4] While the rates in this country have been decreasing over the past decade, our teens experience higher pregnancy and birth rates than do teens in other Western industrialized countries.[5] The vast majority (78%) of these pregnancies are unplanned, and half are terminated by abortion.[6] In 2000 alone, almost half a million babies were born to teen mothers in the U.S.

Studies have shown that:

Teen mothers are less likely to graduate from high school: 7 in 10 teen mothers complete high school. Teen mothers are less likely to go on to college than women who delay childbearing.[7]

Teen mothers earn less and rely on welfare more: Within 5 years after the birth of a first child, 50% of all teen mothers receive welfare.[8]

One in 4 teen mothers have their second child within 2 years of their first.[9]

The children of teenage mothers often begin life at a disadvantage: Compared with children born to older mothers, the children of teen mothers are more likely to be born prematurely and be of low birth weight;[10] experience childhood health problems and hospitalization;[11] and perform poorly in school (e.g., score lower on standardized tests, repeat a grade, or drop out of high school).[12] Children born to teen mothers are also at greater risk of abuse and neglect.[13]

Resources

Teenage pregnancy data are available for your state or city from your state health department and websites such as:

www.teenpregnancy.org

www.agi-usa.org

www.childtrends.org

www.cdc.gov/nccdphp/dash/yrbs/

www.statehealthfacts.kkf.org

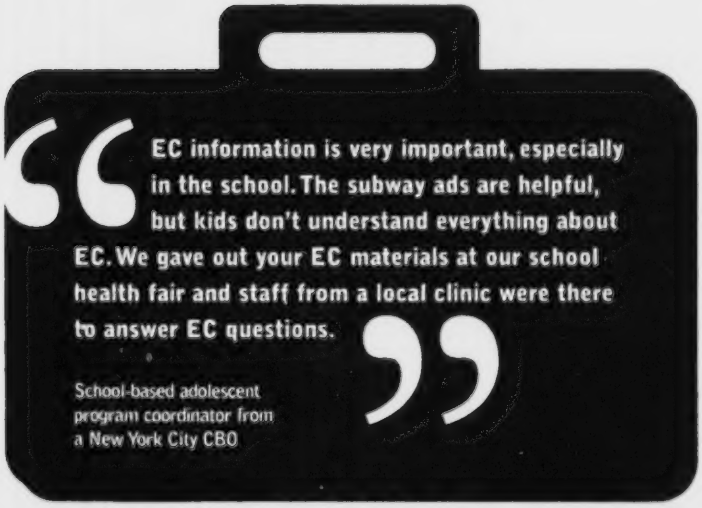
Declining teen pregnancy rates have been attributed to increases in contraceptive use and abstinence. With regard to contraceptive use by adolescents, it is impressive that condom use at first sex almost tripled from 23% in 1982 to 63% in 1995.[14] To their credit, 69% of adolescents used a method at their most recent sexual intercourse; however, the remaining one-third of adolescents (31%) did not use anything.[15] When teens do practice contraception, it is not always used consistently or correctly.[16] Thus, despite the fact that contraceptive use is increasing, hundreds of thousands of teens still remain at risk of pregnancy because of contraceptive nonuse, misuse, or usage failure.

EC provides a second chance to prevent an unintended teenage pregnancy!

It has been estimated that EC could reduce the number of unintended pregnancies and subsequent abortions in the U.S. by as much as 50%.[17] Think of the difference that would make! Without EC information, teens lose this second chance.

PREPARING ADULTS TO TELL TEENS ABOUT EC

One way to ensure that teens are informed about EC is to increase EC awareness among adults who are involved with youth. Teachers, guidance counselors, health practitioners, youth workers, parents, and others can share this information with teens proactively or in response to questions. For example, they may choose to share information with teens in a formal way (e.g., provide EC information in a class on pregnancy prevention) or informally in conversations with youth who they believe are now, or soon to be, sexually active. Adults may also share EC information in response to general EC questions raised by teens. Recent EC media campaigns may prompt teens to ask for factual information as well as the personal opinions of the people they trust. Adults may also be approached by a teen in a moment of crisis: "I didn't use protection"; "The condom broke"; "I was raped"—"What can I do?"


"EC information is very important, especially in the school. The subway ads are helpful, but kids don't understand everything about EC. We gave out your EC materials at our school health fair and staff from a local clinic were there to answer EC questions."
School-based adolescent program coordinator from a New York City CBO

The following tips help adults prepare for these situations.

Know the Facts

The more you know about EC, the better prepared you will be to help adolescents. Take the true-false quiz, "Facts about Emergency Contraceptive Pills," located in Toolbox-4 to assess what you do and don't know about EC. Use this toolkit (Section 1) and the fact sheets in Toolbox-2 to learn the basic facts. In addition, the resources listed at the end of this section will help you obtain up-to-date information on changes in knowledge, policy, and practice.

Be Proactive

Don't wait for a teenager to ask. Discuss EC before s/he asks. Incorporate EC information into a workshop you already teach, start a conversation or ask a question about EC, put up a poster, pass out materials, or do whatever else it takes to give teens accurate information.

Encourage Teens to Think Ahead

Encourage teens to talk to their health care providers about EC before an emergency occurs. Teens can ask for an EC prescription to be filled quickly. Prescriptions can also be filled in advance because the shelf-life for EC products ranges from 3 to 4 years.

Repeat the Information on Different Occasions

Like adults, teens may not process EC information the first time they hear it. Reminding them that there is a backup when contraception is not used or fails can help reinforce the message to stay healthy and safe and, if necessary, take steps to avoid unwanted pregnancy.

Know Where Adolescents in Your Community Can Obtain EC Information, Medical Care, and EC

Refer teens to health care providers who know about EC and are comfortable with prescribing it to adolescents. If possible, refer adolescents to teen-friendly facilities in terms of cost, privacy, confidentiality, hours, service delivery, and access to transportation. Know which hospital emergency departments offer EC to sexual assault survivors.

Help Teens Get EC Immediately

Because EC is most effective the sooner it is taken after unprotected sex, it is extremely important to act quickly. Share information as soon as possible and encourage or help a teen access an EC prescription immediately.

EC ISSUES SPECIFIC TO ADOLESCENTS

People working with adolescents must address some issues that pertain specifically to this age group. Depending on your professional role vis-á-vis teens, you will likely need to be familiar with some of these issues and not others. They include finding or being a teen-friendly service provider; dealing with consent and confidentiality issues, as well as with rape and sexual abuse; helping teens consider whether to involve their parents; and other relevant issues such as cost, involving males, stress, and EC as a bridge to other forms of contraception. These issues are discussed briefly below.

Resources

TEEN-FRIENDLY HEALTH CARE PROVIDERS AND PHARMACISTS

To find a local health care provider or pharmacist who will prescribe EC:

Call the EC Telephone Hotline: 1-888-not-2-late.

Log onto the internet: www.not-2-late.com.

Call 1-800-230-PLAN to find the closest Planned Parenthood.

Teen-Friendly Health Services

Many teens do not have a regular health care provider. Others may not wish to contact their regular provider about EC. Health practitioners who have identified themselves as knowledgeable about EC and willing to see patients of all ages for EC can be found on the not-2-late.com website (see Resources on this page). Because lists may not always be up to date, you might need to call other places to help a teen obtain EC. You may be able to find local EC providers by calling private practitioners themselves, county health departments, community health centers, family planning clinics, and rape crisis centers. It is best if the practitioners you identify offer teen-friendly services. For example, in urban communities, you may be able to locate specifically designated teen clinics. Planned Parenthood clinics also provide teen-friendly services.

Did You Know?

In the U.S., there are no state laws that require parental consent or notification for counseling or provision of contraceptive services, including EC. In fact, laws in 27 states and the District of Columbia explicitly give teens the right to consent for contraceptive services. Other states leave the decision to inform parents to the discretion of the physician. Texas and Utah prohibit the use of state funds to provide contraceptive services to minors without parental consent.[18] Clinics supported by federal Title X funding are required to provide confidential reproductive health services to minors.

In some states—Washington, California, New Mexico, and Alaska—pharmacists can provide EC without a doctor's prescription. In these states, doctors and pharmacists have collaborative practice agreements and receive special training in order to be qualified to dispense EC directly to the patient. (Pharmacy access may soon be available in other states.)

We recommend that you (or teens you work with) contact a few of these providers to determine whether they are geared to meeting the special needs of teenagers and what their availability is on evenings and weekends. Have their names, phone numbers, addresses, and hours on hand in case you need to make a referral. Share this list with other adults who may need it.

Consent and Confidentiality

In the U. S., youth have the legal right to consent to confidential contraceptive services, testing, treatment of HIV and other STDs, and other specific services. One reason that the protection of confidentiality is so important is that it reduces the barriers for contact between a teen and health care professionals. Information about specific laws governing a minor's rights to medical care can be found on the website for the Alan Guttmacher Institute: **www.agi-usa.org.**

It is important to inform teens that their confidentiality may be breached by private health insurance companies. Private insurance companies routinely send a list of all bills paid—such as the doctor's visit and medications provided—to the primary insured person, usually the parent. (This may not be a problem if the teen is covered by government insurance such as Medicaid, Child Health Plus, or California's Family PACT.) Teens who are concerned about confidentiality and are covered by private insurance may want to find a clinic that offers free or low-cost services to teens. An alternative is that the teen pay for the visit or medication with cash.

The professional ethics of "licensed" staff, such as social workers, require them to protect information given in confidence. Although teachers may not have the same requirements, parental notification would likely undermine their ability to counsel youth and refer them to professional care. Some schools or CBOs may have specific policies about whether and how to involve parents when teens have confided in a member of the staff. It is wise to check in advance with the school or CBO administration about policies pertaining to these situations.

Parents, Guardians, and Trusted Adults

Teens often name parents first as trusted sources of information about sexuality and relationships. Thus, it is important that parents are informed about EC. Teens then name adults who work with youth.[19] If a teen comes to you worried that she may be pregnant, help her decide whether she has a parent or other responsible adult to help her make

health care decisions and encourage her to involve this individual. However, if the teen decides not to involve a parent or guardian at this point, you are under no legal obligation to notify the parent.

Rape and Sexual Abuse

If a teen asking about EC says that she has been raped or sexually abused, give her the hotline number of the local sexual assault center. The center will offer her options, including information about services at a local hospital and a forensic sexual assault exam. An advocate at the sexual assault center can meet her at the hospital and stay with her during the exam. Tell the teen that EC is a medication she can ask for at the hospital to help prevent pregnancy. Be sure to inform her that she will need to ask for EC; not all hospitals will give her EC unless she asks for it, and only a small minority of hospitals affiliated with the Catholic Church will provide information about it. Many victims of sexual assault do not choose to be treated at a hospital; it is extremely important to give them information about EC and help those who want it to obtain it quickly.

If a very young teen asks for help or has a partner who is significantly older, you should suspect coercive sex and be prepared to follow school or organizational protocols for identifying and responding to child abuse. Youth-serving professionals need to be prepared by knowing the state laws as well as the policies and practices of their work setting.

Involving Males

Since 9 in 10 males in the U.S. are sexually experienced by the time they reach age 20, they need to know about birth control and condoms.[20] However, they are unlikely to get this information from a health care provider. A recent study conducted by the Alan Guttmacher Institute found that only 14% of men have an annual medical visit for reproductive health, and adolescent males are less likely than older men to seek care even though they are more likely to contract STDs and be responsible for unwanted pregnancies.[22]

At present, marketing messages for EC and other birth control methods generally target females in women's magazines and female-oriented clinics. It is important to ensure that males have adequate information about EC and that staff in the helping professions model the expectation that males should be involved in birth control decisions.

Fact

MANY YOUNG WOMEN EXPERIENCE FORCED SEX. Approximately 18% of women experience an attempted or completed rape. More than half (54%) were younger than age 18 when this occurred. A large percentage (39%) of child and adolescent rape victims were assaulted by a relative (other than a spouse) and 47% by an acquaintance.[21]

Resource

THE NATIONAL SEXUAL VIOLENCE RESOURCE CENTER, www.nsvrc.org, has contact information for the state sexual assault coalition to help locate the closest sexual assault center.

Incidents of sexual abuse involving minors must be reported to the state child abuse hotline (or appropriate reporting institution). Call the NATIONAL CHILD ABUSE HOTLINE, 1-800-422-4453, to report child sexual abuse/assault.

Stress

Teens who have had unprotected intercourse may feel very stressed because of fear of pregnancy, STDs, and HIV; embarrassment about not using contraception or having a problem with it; and the experience of coercion or sexual assault. Stress may be intensified by relationship problems, family conflicts, substance use, poverty, and any number of other psychosocial factors.[23] It is important that the helping adult be calm and supportive while guiding the teen through the immediate crisis. A positive experience dealing with this crisis may predispose the teen to seek help for other personal problems.

EC as a Bridge to More Reliable Forms of Contraception

ECPs are an important backup method, but they are not recommended for routine birth control because they are less effective than other contraceptives, do not protect against HIV and other STDs, and may have unpleasant side effects. Use of ECPs can be an important first step to better, more reliable birth control. Teens should always be encouraged to visit a health care provider—the next step in assuming responsibility for their health and their future.

STAYING UP TO DATE ON THE ISSUES

Resources

TO HELP YOU STAY UP TO DATE ABOUT EC

* **Association of Reproductive Health Professionals** www.arhp.org
* **Emergency Contraception Website** www.not-2-late.com **and Hotline 1-888-Not-2-Late or 1-888-668-2528**
* **PRODUCTS: Plan B® www.go2planb.com and PREVEN® www.preven.com**
* **Planned Parenthood Federation of America** www.plannedparenthood.com
* **Population Council** www.popcouncil.org/faqs/emergencycontraception.html
* **Reproductive Health Technologies Project** www.rhtp.org

The EC field is dynamic. Laws and policies concerning EC access are changing. For example the 72-hour time frame for taking EC is now 120 hours and one-dose regimens are being developed. It is important to stay up to date on these issues. Three key issues to watch are described below. The resources on the next page can help you stay informed about EC.

Pharmacy Access

EC can be obtained directly from pharmacists, without a prescription, in four states—Alaska, California, New Mexico and Washington.[24] In three states, after completing a required training program, pharmacists can provide EC under a signed protocol with an authorized prescriber. (See page 22 to locate participating pharmacies.) In New Mexico, the law permits pharmacists to provide EC under a state Board of Pharmacy protocol. Several other states are organizing to pass pharmacy-access legislation in the near future.

EC Availability Without Prescription

Advocates are working to make EC available over the counter in the U.S. for several compelling reasons. First, most unprotected sex occurs on weekends and holidays when it is often difficult for women to obtain a prescription for EC. Second, EC is more effective the sooner after unprotected sex that it is used. Third, EC is available without a prescription in other countries with no adverse effects to women. For example, EC is available over the counter in Norway and Sweden. In 25 other countries, it is available from licensed pharmacists who provide counseling or instruction but dispense it without a prescription. Among the countries with "behind-the-counter" availability are Albania, Congo, France, Israel, Portugal, South Africa, Sri Lanka, and the United Kingdom.

In the U.S., steps have been taken to make EC readily available to women without a prescription. In September 2001, a citizens' petition signed by 90 health organizations, including the Society for Adolescent Medicine, the Association for Reproductive Health Professionals, and the American Public Health Association, was presented to the FDA. Also, the Women's Capital Corporation, manufacturer of Plan B®, is preparing an FDA application to switch its product to nonprescription status.

Extending the EC Window from 3 to 5 Days

Research shows that the sooner EC is taken after unprotected sex, the more effective it is. Preliminary findings from recent research offer evidence that ECPs are effective 4 or 5 days after unprotected intercourse.[25] And because EC is not harmful, an increasing number of practitioners will prescribe ECPs up to 120 hours (5 days) after unprotected sex.

GUIDE TO TEEN-FRIENDLY EC MATERIALS AND INFORMATION

To increase EC awareness among youth, it is helpful to have print materials (e.g., EC posters, fact sheets, brochures, wallet cards, and other handouts) that capture their attention and provide easy-to-understand information. Click on the "educational and promotional materials" button on the **www.not-2-late.com** website for a description of the materials developed for AED's Emergency Contraception and Adolescents Project.[26] These materials included a poster, brochure, wallet card, palm card, and gummed pads with tear-off sheets (see Toolbox-2 also). The process we went through to create them is described in Toolbox-8 as part of the "New York Story." Listed on the next page are sources for adolescent-friendly materials available on the World Wide Web. Before using any of these materials, review them with colleagues, parents, and teens to assess whether they would be appropriate for the teens you want to reach. For example, ask teens if they would be interested in learning more about EC if they saw the materials and if they understand the content.

Groups interested in reproducing AED's materials can contact the agency that designed and printed them (Adept Visual Dynamics, 212-690-4641; **adeptvis@msn.com**; **www.adeptvis.com**). Adept Visual Dynamics already has our template and can easily substitute names of teen-friendly clinics in your community. In addition, the list on the next page includes a variety of websites where you can view and order free, low-cost EC materials.

n

Emergency Contraception

Teens

TEEN-FRIENDLY EC MATERIALS AVAILABLE ON THE WEB

*** Advocates for Youth**

www.advocatesforyouth.org/news/feature/ecps.htm

Free EC materials, including an 8-page teen pamphlet, public service announcements, lesson plans, fact sheets for youth-serving professionals about EC and adolescents, and lesson plans.

*** Back Up Your Birth Control**

www.backupyourbirthcontrol.org

Various forms of free EC information—fact sheets, letters, and posters.

*** Johns Hopkins University/Center for Communication Programs—Media/Materials Clearinghouse**

www.jhuccp.org/mmc

A wide range of materials on various topics for diverse audiences; costs included.

*** Not-2-Late EC Materials Data Base**

http://ec.princeton.edu/ecmaterials

Maintained by the Association of Reproductive Health Professionals, the database contains EC materials for a variety of audiences; costs included.

*** Planned Parenthood Federation of America**

www.plannedparenthood.com

Several free EC fact sheets available.

*** Program for Appropriate Technologies in Health**

www.path.org/resources/ec_resources.htm

Fact sheets in Spanish and English, as well as downloadable EC brochures in 13 languages (Amharic, Arabic, Cambodian, Chinese, English, Haitian-Creole, Korean, Laotian, Portuguese, Russian, Somali, Spanish, and Vietnamese).

*** Reproductive Health Technologies Project**

www.rhtp.org

Free EC posters, pamphlets available.

WEBSITES FOR YOUTH

Many youth now use the Internet to find answers to their health questions. According to a recent study by the Kaiser Family Foundation, 68% of U.S. youth and young adults, ages 12 to 24, have gone on line for health information; and 44% have used the Internet to obtain information on sexual health, including pregnancy, birth control, HIV/AIDS or other STDs.[27]

The following list contains teen-friendly sites containing information about EC. Toolbox–2 contains a handout with EC information for teens.

ADDRESS	NAME	ORGANIZATION
www.advocatesforyouth.org	**Advocates for Youth**	Advocates for Youth
www.ppsp.org/askbeth/askbeth.html	**Ask Beth**	Planned Parenthood of Southeastern Pennsylvania
www.drdrew.com	**Dr. Drew**	Drew Pinsky, M.D.
www.goaskalice.columbia.edu	**Go Ask Alice**	Health Education Program, Columbia University
www.iwannaknow.org	**I Wanna Know**	American Social Health Association
www.itsyoursexlife.org	**It's Your (Sex) Life**	Kaiser Family Foundation
www.kidshealth.org/teen	**KidsHealth**	Nemours Foundation, Center for Children's Health Media
www.sxetc.org	**Sex, Etc.**	Network for Family Life Education, State University of New Jersey at Rutgers
www.teenwire.org	**Teenwire**	Planned Parenthood Federation of America
www.teengrowth.org	**Teen Growth**	A team of pediatricians

DIFFICULT QUESTIONS AND RESPONSES ABOUT EC AND TEENAGERS

Anyone who has worked with adolescents on sexuality-related issues often has to respond to two distinct kinds of questions. The first type of question is informational and requires clear explanations of complicated medical facts. The second type, which we refer to as "difficult" questions, includes not so much questions as expressions of beliefs, discomfort, or even anger.

While the media surrounds young people with highly sexualized content, the fact is that many adults are very uncomfortable with sexuality and are particularly uncomfortable with the fact that many teenagers are sexually active. The authors of the landmark Alan Guttmacher study comparing the high U.S. rates of teen pregnancy to the far lower rates in western Europe and Canada concluded that this is one of the main reasons our teens are at risk.[28] We find it difficult to provide information or services because it means acknowledging teen sexuality as a healthy aspect of human development. Teens pay a high price for this discomfort.

So what do you say when asked in a challenging tone, "Are teens really old enough to handle EC?" and you suspect the speaker is really saying, "I don't think teens are old enough to be having sex, and I don't want to 'encourage' them by letting them know about EC." Simply giving the speaker the facts might not work; we know how difficult it is to change attitudes. It is probably best to acknowledge the speaker's concerns, confirm that this is a difficult discussion, and state that although we may not always agree, we are all trying to achieve the same goals: safe and healthy teens.

The responses to the "difficult" questions that follow are less about facts (review section 1 of this toolkit for facts) and more about how to keep a discussion open when talking with colleagues who don't necessarily share our beliefs. With that in mind, here are some approaches to difficult questions we have encountered in school and CBO trainings.

Are teens really old enough to handle EC?

All of us would agree that teens should be older—not just to use EC, but also to deal with sex, a serious relationship, and many other things. We might counsel them to wait until they are older, but if they are going to have sex, then we should help them protect themselves. Medically, EC is not difficult to handle—certainly no more difficult than complying with daily medications or, for that matter, daily oral contraceptives. And, surely, if a teen is not old enough to handle EC, she is probably not old enough to deal with having an abortion, or going through pregnancy and labor, and being a parent. So, let's do what we can to prevent this pregnancy—including letting her know that unprotected intercourse does not have to result in pregnancy.

Won't teen girls become more promiscuous if there is an easy way out?

The findings of several recent studies allow us to say with confidence that the availability of contraception does not lead to promiscuity. When information about contraception is provided in schools, or even when condoms are available free in schools, teens do not start having sex earlier and the rate of sexual activity does not increase.[29,30] Studies in Europe, where ECPs have been on the market long enough for researchers to assess their impact, indicate that "neither EC, nor any contraceptive method has been statistically

proven to increase sexual activity among users."[31] Any concern about promiscuity—in young women or young men—should be addressed, but access to ECPs does not trigger promiscuity, and information about ECPs should not be withheld from young women and men who want to act responsibly.

Won't teens come to rely on EC and use it all the time?

There is no evidence that educating teens about EC or even giving them ECPs in advance will result in routine use.[32] This may be because the side effects of ECPs (e.g., nausea and vomiting) can be uncomfortable. Also, used regularly, EC can be expensive; it is also less effective than other birth control methods and offers no protection against HIV and other STDs. Nevertheless, it is important to know that there is no medical reason to worry about the physical consequences of repeated use. ECPs are essentially just two concentrated doses of birth control pills taken 12 hours apart. Millions of teenagers take far more birth control pills than that every month. A recent article about repeated use concluded that it is reasonable for women who have infrequent sex to use ECPs as a primary method of birth control. Safety is high, and pregnancy rates compare favorably with other forms of contraceptives that a person having infrequent sex generally uses such as barrier methods, withdrawal, and periodic abstinence.[33]

Shouldn't teens just be abstinent?

Who doesn't want teens—particularly younger teens—to be abstinent? If you are concerned about the prevention of unintended pregnancies, there is no better method than abstinence. Having agreed on that, where do we go next? The fact is, not all teens are abstaining from sex. While encouraging abstinence, we still have a responsibility to help sexually active teens prevent pregnancy, and part of that responsibility is letting them know about EC.

From the Field

REPEATED USE

"When I give workshops on EC and that issue gets raised, I ask, "What is your real fear?" Because there is no medical reason not to prescribe EC repeatedly, even within the same cycle. As an example, I had a patient recently who I prescribed EC to 8 times within one month. By the eighth time, she decided to switch to a more effective birth control method. She needed time to figure things out for herself and not get pregnant in the meantime."

Physician, Mount Sinai Adolescent Health Center, New York City

How can teens really tell if they need EC?

Because teens need to contact a health practitioner or pharmacist to obtain EC, they will receive the information they need about whether they are actually at risk of pregnancy. But many teens are ignorant of the basic facts about their bodies, how pregnancy occurs, and what they can do to avoid unintended pregnancy. Teens still believe many myths about sex and pregnancy prevention. That is why we recommend that youth receive information about EC in the context of health education or broader discussions about reproductive health and preventive care related to pregnancy and STDs. If comprehensive health education is not provided to students in your school or CBO each year, that is all the more reason to make written information or lists of websites available to students.

Shouldn't their parents/guardians be involved?

Studies show that most teens would like to be able to talk to their parents when they are faced with a crisis . . . and most do.[34] If teenagers come to you concerned about a possible pregnancy, you would certainly talk with them about involving their parents. But whether you should alert the parents/guardians that their daughter (or son) has come to you about a pregnancy scare is a different issue. In the U.S., youth generally have the legal right to consent for confidential contraceptive services, testing, and treatment of HIV and other STDs, as well as other specific services. A study published in the *Journal of the American Medical Association* found that without the protection of confidentiality, 60% of teenage girls said they would stop seeking reproductive health services![35]

Should young men know about EC?

As long as it takes two to become pregnant, we should be talking to young men about EC, as well as about every other form of contraception.[36] Yes, it is possible that some young men may think that using condoms is unnecessary if their partners take ECPs—and we will need to address that attitude. However, focus groups conducted with patients at the Young Men's Clinic in New York City suggest that there will be many more young men who are caring, responsible partners who understand the consequences of an unplanned pregnancy for themselves and the young women involved. We need to provide guidance and information to both groups of young men.

Isn't this too controversial?

EC should be no more or less controversial than any other form of birth control, and a large majority of parents feel that their children should learn about birth control in school.[37] People have very strong opinions about teens and sex but we can all agree that we want them to be safe. One reason that EC is controversial is that people still confuse it with mifepristone, also called RU 486 and the "French abortion pill." EC works before implantation and cannot terminate a pregnancy. Recent studies on how ECPs actually work suggest that they most likely delay ovulation and prevent fertilization. Evidence of post-fertilization effects have been harder to detect.

When it comes to teens, we are all working in an area where there is much controversy. However, this should never keep us from giving full and accurate information to the young people who seek our guidance and deserve the most up-to-date information about all their options.

FOOTNOTES

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[2] U.S. Department of Health and Human Services, June 10, 2002, *Preventing Teenage Pregnancy*, www.hhs.gov/news/press/2002pres/teenpreg.html.

[3] Alan Guttmacher Institute, 1999, Teen sex and pregnancy, *Facts in Brief*, New York: AGI. www.guttmacher.org/pubs/fb_teen_sex.html.

[4] The National Campaign to Prevent Teen Pregnancy, 2002, *General Facts and Stats*, www.teenpregnancy.org/resources/data/genfact.asp.

[5] Alan Guttmacher Institute, 2002, Teen pregnancy. trends and lessons learned, *Issues in Brief*, New York: AGI. www.guttmacher.org/pubs/ib_1-02.html.

[6] Alan Guttmacher Institute, see endnote 3.

[7] Ibid.

[8] National Campaign to Prevent Teen Pregnancy,1997, *Whatever Happened to Children: the Problem of Teen Pregnancy in the United States*, Washington, D.C.: author.

[9] Ibid.

[10] Ibid.

[11] Alan Guttmacher Institute, see endnote 3.

[12] National Campaign to Prevent Teen Pregnancy, see endnote 7.

[13] The National Campaign to Prevent Teen Pregnancy, 2001, *Facts and Stats*, Washington, D.C.

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[24] The Pharmacy Access Partnership, a Center of the nonprofit Public Health Institute, is the lead agency for the California initiative. Its website www.PharmacyAccess.org describes the initiative and provides information about training resources for pharmacists. Contact information: Telephone 510-272-0150, e-mail info@PharmacyAccess.org.

[25] The not-2-late website: http://ec.princeton.edu/questions/ectime.html.

[26] Emergency Contraception and Adolescents: Increasing Awareness, Access, and Appropriate Use was the first in a series of projects that led to AED's current project, *You Can't Teach What You Don't Know*. Earlier projects were supported by the Open Society Institute, The General Services and Turner Foundations, and the Child Welfare and John Merck Funds.

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Section

Emergency Contraception

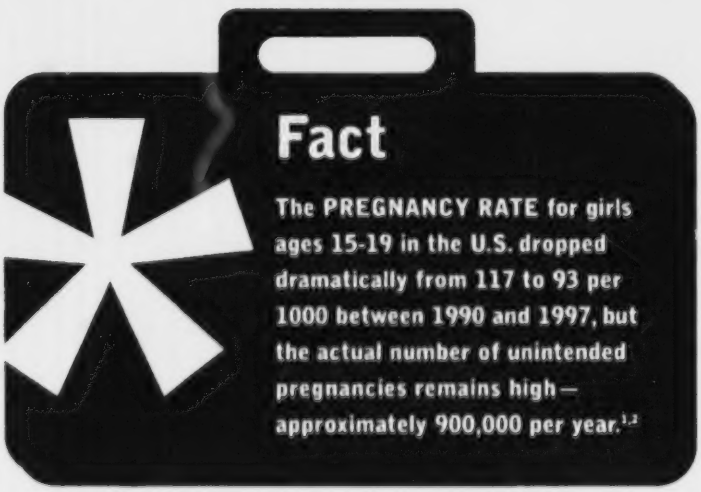
Schools

Explains why pregnancy prevention matters to schools and how to increase EC awareness in schools and respond to questions that may arise in the school context.

Section 3 Emergency Contraception & Schools

School systems and schools address pregnancy prevention in a variety of ways, ranging from those that do little to those with comprehensive programs addressing pregnancy and HIV/AIDS prevention. This section of the toolkit is designed to help school staff increase emergency contraception awareness within the context of the school system or school. This may mean ensuring that the school nurse or other appropriate support staff know about EC, adding information about EC to health education efforts already underway in the school, or conducting a targeted schoolwide EC awareness campaign. While you may not be able to implement all the suggestions in this section, do whatever possible to increase EC awareness in your school to help youth avoid unplanned pregnancy.

We hope the information in this section will help whether you work directly with students as a teacher, guidance counselor, social worker, school nurse, school-based health center staff, or specialist in pregnancy, HIV/STD, and alcohol and drug prevention; or whether you work with teachers and school staff as a district or school administrator, a curriculum developer, or teacher trainer. Staff of CBOs who work in school settings might find helpful information in this section as well as in section 5, which focuses exclusively on CBOs. School-based health center staff may want to come back to this section after reading section 4 first.


Fact
The PREGNANCY RATE for girls ages 15-19 in the U.S. dropped dramatically from 117 to 93 per 1000 between 1990 and 1997, but the actual number of unintended pregnancies remains high—approximately 900,000 per year.[1,2]

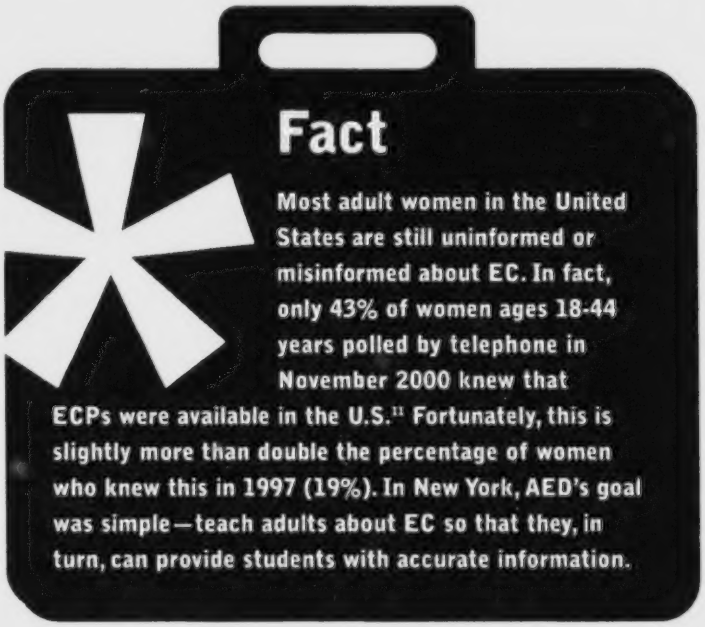
PREGNANCY PREVENTION MATTERS TO SCHOOLS

Approximately 50% of the 14 million students enrolled in secondary schools in the U.S. are sexually active (see graph in section 2, page 19).[1] There are many compelling reasons for schools to play a role in reducing the rate of unintended pregnancy among students. Unintended pregnancy and childbearing have a huge impact on educational outcomes, as well as on the health status and economic futures of young women and their offspring.[4] As the data in section 2 show, teen mothers are less likely to graduate from high school and go on to college, and their children are more likely to perform poorly in school.[5]

Schools recognize that it is more difficult to achieve their academic mission if their students are preoccupied (counselors often use the term "panicked") with worry about a possible pregnancy or if they are pregnant or supporting a baby.[6] Many high schools already cover sexuality, reproductive health, and contraception as part of formally approved family life education programs. Five health education programs that have been found effective after rigorous evaluation are widely used in schools.[7] Other school systems may not have guidelines for family life education or choose not to force compliance. Under these conditions, schools set their own guidelines.

Districts differ with regard to the population they choose to target for pregnancy prevention. Many schools feel a responsibility to help sexually active teens protect themselves from pregnancy and sexually transmitted infections, including HIV. Some schools extend their concern to the teens who have not yet had sex to both support their decisions to delay sex and ensure that they know how to protect themselves when they do decide to become sexually active. Some people worry that sex education programs covering contraception "give a mixed message" and increase sexual activity. Fortunately, there is scientific evidence that providing teens with information about the benefits and limitations of contraception does not lead to earlier initiation of sex nor increase the frequency of sex or the number of sexual partners.[8]

The overwhelming majority of parents of teens are supportive of sex education that provides practical information and skills. According to a national survey (1999), 90% of parents of students in grades 7 to 12 reported that they wanted schools to teach their children the basics about reproduction and birth control. They also wanted schools to teach students practical skills like how to use condoms (85%) and talk to partners about condoms and birth control (88%). Parents also wanted schools to cover controversial issues such as abortion (79%) in a way that acknowledges the range of differing views.[9] In a recent survey of voters polled specifically on the topic of EC, 77% said that teens should have access to EC information.[10]


Fact
Most adult women in the United States are still uninformed or misinformed about EC. In fact, only 43% of women ages 18-44 years polled by telephone in November 2000 knew that ECPs were available in the U.S.[11] Fortunately, this is slightly more than double the percentage of women who knew this in 1997 (19%). In New York, AED's goal was simple—teach adults about EC so that they, in turn, can provide students with accurate information.

Adolescents turn to teachers, counselors, administrators, coaches, volunteers, and others for information and guidance, both academic and personal. It is not surprising that students report that, next to their families, they consider teachers and counselors the most reliable sources of sexuality-related information.[12] EC holds great promise to significantly decrease the rate of unintended teen pregnancy in the U.S. Unfortunately adolescents, parents, and the school personnel they look to for information and guidance are still largely uninformed about EC.

In this section we provide many simple ideas for increasing EC awareness. For example, in schools that already offer health education addressing reproductive health and sexuality, EC information can be easily integrated into existing lesson plans. Schools can also provide information about EC through health services (e.g., in nurses' offices and

Did You Know?
In France and Great Britain, school nurses can give out EC in school. In Great Britain, they can dispense EC regardless of the age of the student and with complete confidentiality.[13]

school-based or school-linked health centers), through support services (e.g., programs for teen mothers and their babies), at special events (e.g., assemblies and health fairs), and at strategic points of information dissemination (e.g., libraries, bulletin boards, and resource rooms). How do you begin?

Five steps for providing school staff, parents, and students with EC information include:

* **Establish the need**
* **Lay the ground work**
* **Identify opportunities**
* **Educate adults**
* **Educate and involve students**

STEP 1: ESTABLISH THE NEED

It is helpful to begin with an assessment of your situation. Thinking about these questions can help you decide where to start.

Questions to Help You Begin EC Outreach

1. Is teen pregnancy an issue in your district, school, and community?

If YES: What is the scope of the problem?
What are the issues and concerns?

2. Are there any current efforts in the schools to prevent teen pregnancy?

If YES: What are they?
Are they formal or informal?
Who is involved?

3. Is there any information or education about EC already in the school system?

If YES: Are the educators adequately trained?
Could more staff use training?
How is the information disseminated?
Who does the information reach?
Who doesn't it reach?
What needs are not being met?

4. Are there teens who are already informed about EC?

If YES: How can they help disseminate information to adults and peers?

When you have answered these questions, you can start to lay the groundwork for increasing EC awareness in your school.

STEP 2: LAY THE GROUNDWORK

This step includes understanding the relevant policies in your district and school; identifying allies and advisors; and preparing to address school-specific issues.

Understand School and District Policies

To work in schools effectively around issues of sexuality and sexuality education requires understanding the relevant distict and school policies—both explicit and implicit. It is unlikely that a district or school will have written policies on all the issues listed below. Nonetheless, before you begin planning activities to increase EC awareness, it's important to be aware of district and/or school policies or implicit understandings about:

* **Teaching about contraception in health class**
* **Talking to a student about contraception**
* **Confidentiality**
* **Approving health outreach materials for use in schools**
* **Posting information in public spaces, classrooms, or health offices**
* **Handing out information (brochures, etc.) about contraception**
* **Providing contraceptives in schools**

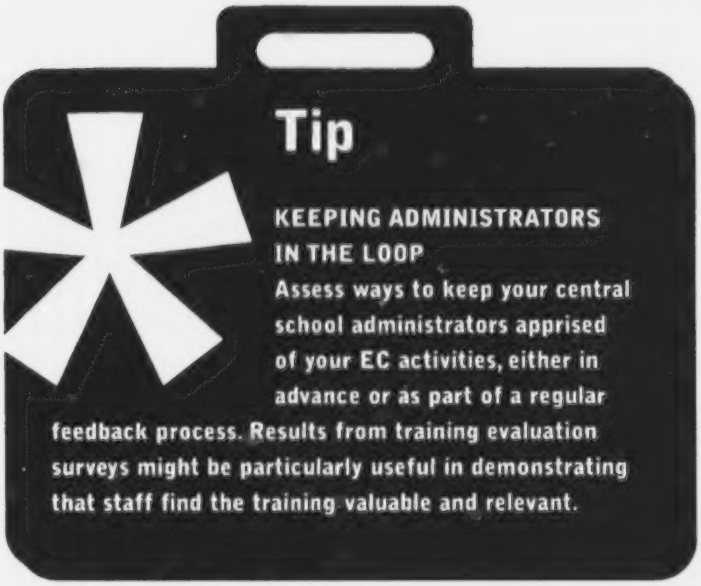
The district plays an important role in establishing, promoting, and clarifying these policies. We can guarantee that if you are going to train school staff about EC, they will ask if they have approval to give the information to students. You are likely to encounter at least one of three scenarios:

Good News: The district supports the dissemination of birth control information to students. If you find yourself in this enviable position, get it in writing and give copies to the adults you train.

From the Field

THE NEW YORK STORY

In New York City, we could not gain the written approval of the central school administration for our EC training initiative, "You Can't Teach What You Don't Know." However, we were told to work closely with the school system's pregnancy prevention initiative, in which we found a strong ally. Through this contact, we were able to offer EC training to assistant principals for health and physical education and then to other school staff to whom EC information was immediately relevant. The administration informed us that it had no formal process for approving and disseminating EC awareness materials for students. Administrators told us that outreach to students in each school should be "consistent with local community values."


Tip
KEEPING ADMINISTRATORS IN THE LOOP
Assess ways to keep your central school administrators apprised of your EC activities, either in advance or as part of a regular feedback process. Results from training evaluation surveys might be particularly useful in demonstrating that staff find the training valuable and relevant.

No News: There are no written policies, and the district will allow you to provide EC information as long as no controversy erupts. The New York Story (see "From the Field" above and Toolbox-8) describes how "no news was good news."

Bad News: The district has strictly forbidden the dissemination of birth control information in general, or EC information specifically, to staff and students. If you find yourself in a district like this, your work should begin with EC education aimed at key leaders and with advocacy to change policies.

Based on AED's experience in the New York City public schools, we know that school staff feel more comfortable with the explicit blessing of the district. Nevertheless, staff members often do what they think is right, regardless, and the district is unlikely to create a fuss if there is no vociferous opposition. Contexts vary, of course. AED's experience was that during its two-year EC school-based awareness project, there were no complaints. On the contrary, requests for training and EC materials increased over time.

Identify Advisors and Allies

An important part of laying the groundwork is to identify a group of advisors and allies whom you can call on individually or as a group for support.

Advisors are experts you can call on when you need technical help. They know your state's laws and political environment; they are EC experts, adolescent health practitioners, legal experts, and educators. Examples of advisors include:

* **Clinicians to answer medical questions about EC and legitimize your efforts**
* **Public health experts to frame the pregnancy prevention issue and help develop outreach and training strategies**
* **Researchers to inform you about the latest studies about EC and adolescents**
* **Advocacy advisors to gain support for your efforts**
* **Legal advisors to answer questions about confidentiality and consent**
* **District and central board of education staff to help with approval and access**
* **School-based staff to help with access and understanding the school context**

Allies are all your advisors, plus the many individuals in districts and schools who care about these issues and support the dissemination of EC information in schools. These are typically the staff members who already talk to youth about their health or the ones who are brought in to advise teens who become pregnant. Allies are important because they can actively support your efforts or back you up if there is controversy.

One of the most potent, but often silent, allies are parents, who overwhelmingly support sex education in school. As previously noted, the majority of parents want schools to teach their children the basics about reproduction and birth control. Although most parents are potentially valuable allies, they generally are not much better informed about EC than their teens.

Some schools are reluctant to reach out to parents and too often their concern about controversy leads to unnecessary self-censoring. The specter of irate parents is often raised by people who are uncomfortable with schools teaching about birth control or condoms.

It would not be surprising, therefore, if you have mixed feelings about reaching out to parents. No school wants to be embroiled in controversy. Since you know the school's parents, as well the available resources, you are the best judge of how to involve parents in EC awareness efforts.

Fact sheets in Toolbox-2 can be disseminated to parents, especially when accompanied by a letter from a trusted school doctor, nurse, teacher or administrator. Parents might also be reached through presentations at parent nights, PTA meetings, or during parent-teacher conferences. Again, how to reach parents depends on the context. Although it is unlikely that you will face significant opposition from parents, it is wise to prepare for it with your advisors and alert them at the first sign of difficulty.

Address School-Specific Questions

In an earlier discussion of EC and Adolescents (section 2), we distinguished between questions that might require finding ways to explain complicated medical facts and the "difficult" questions that are not so much questions as expressions of beliefs. Many people have strong beliefs about the topics covered in this toolkit. Some might be uncomfortable with the fact that teenagers are sexually active and doubly uncomfortable about schools becoming involved with pregnancy prevention. It is a good idea to try to distinguish between factual questions and difficult questions that are related to beliefs. Both types of questions are important but should be approached differently.

Before reading this next section, you might want to review pages 29–31 in section 2, which deal with more general EC questions. The questions and responses below address school-specific issues.

Why should schools be responsible, anyway? Shouldn't this be taken care of by families?

Schools have always considered student health as part of their mission. For decades, public schools have conducted eye, ear and general health exams on site and have taught students about healthy life styles, from nutrition to avoiding risk behaviors. Sexuality education and reproductive health have long been included in this mission. A student who drops out because of pregnancy is at a serious educational disadvantage. Families and schools are partners in this area. Frequently parents appreciate that the school takes on issues that parents have difficulty talking about. And, with EC, it is likely that parents will rely even more heavily on the school-based professional simply because they are unfamiliar with EC themselves.

How can I possibly fit one more thing into the curriculum?

Very few people who work in schools have the time to add a new topic to their curriculum. The good news is that you really don't have to. You probably cover pregnancy prevention in your curriculum already—or you wouldn't be reading this! EC isn't "one more thing:" It is up-to-date information on a new contraceptive method. So you might need to update your curriculum, but you don't have to cover a whole new topic.

What if I encounter resistance?

Probably the best strategies for coping with resistance to EC are the ones that you're already using in your pregnancy prevention work: 1) whenever possible, form partnerships with supportive parents and school personnel; 2) provide information on pregnancy prevention, including EC, within the context of comprehensive health education; 3) seek out materials that will catch a teenager's attention but are not unnecessarily controversial; and 4) keep your sense of humor.

Do I need parental approval to provide EC education?

If EC information is given within the existing family life education program in the school, the same parent-consent process already in place should apply. When it comes to referring a student to a medical provider, confidentiality is crucial. Although school staff understand the importance of parental involvement, we know that if they mandate it, some teens who desperately need professional help won't ask for it. For this reason, the privacy laws governing reproductive health care are different from those governing other health care issues. That said, teens should always be encouraged to involve a responsible adult in their health care decisions. However, the decision of who to involve and when is up to them.

Is EC information appropriate for middle school students?

The short answer is that if your middle school students are sexually active or becoming sexually active, they definitely need information about EC. (Check with the health department for rates of pregnancy in the 10- to 14-years age group in your community.) A more realistic answer to this question probably should correspond to the type of sex education and reproductive health information your middle school currently provides. If a middle school provides sex education that includes information about pregnancy prevention, then it is appropriate to inform students about EC. Even if sexuality education that covers contraception is not considered appropriate for your middle school students, it is important to ensure that key health and counseling staff know about EC.

WHAT IF MY SCHOOL DOESN'T TEACH ANYTHING ABOUT CONTRACEPTION?

If your school does not currently offer sex education, be aware that most decisions about curriculum are made at the state and local levels. If you have any questions about what can be taught, call the appropriate official.[14] If your school or district has never before offered sexuality education, there are many resources to help you plan a program and gain approval. Two good places to start are the Centers for Disease Control and Prevention, Division of Adolescent and School Health (www.cdc.gov/nccdphp/dash) and your state's office of comprehensive school health, which may be located in your state's education or health department.

STEP 3: IDENTIFY OPPORTUNITIES

District and school personnel can disseminate EC information to staff and students in several ways. The list below summarizes several simple, low-cost strategies. Because each school system and school is different, we provide a range of strategies. Choose the ones that are right for your context. The strategies below are described in detail in steps 4 and 5, and the toolbox contains helpful resources for implementing many of them.

INCREASING EC AWARENESS

	What Districts Can Do	What Schools Can Do
Educate and train staff	Inform district staff about EC. Identify trainers, provide training time, materials, and resources for training school staff. (See Toolbox-3 for a sample staff training presentation.)	Inform school staff about EC through training and material dissemination.
	Involve parents in approving health education curricula.	Inform parents about EC by letter, at open school night, or at parents' meetings. (See Toolbox-2 for EC fact sheets.)
Educate and involve students	Approve and promote curricula that include information about EC. If districts approve community-based organizations that cover sex education topics, ask that they cover EC information.	Integrate EC information in health education classes. (See Toolbox-4 for a sample EC lesson.)
	Approve and obtain EC awareness materials that schools can make available to students.	Talk to students. Disseminate a variety of EC awareness materials to students. Tell them where to find EC information on the Internet.
	Provide explicit approval and support for involving students in EC awareness activities.	Involve students in EC education and advocacy.

Think about the activities listed above in relation to what is already happening in your school/district. It is likely that many people are already involved in pregnancy prevention in both formal and informal ways. Use the two work sheets on the next page to think about who these people are and reflect on these questions:

* **Do these professionals exist in my school/district?**
* **What roles do or could they play in terms of pregnancy prevention?**
* **What do they already know about EC, contraception, and pregnancy prevention?**
* **Who is the contact person for each group and what would be the best strategy for contacting her/him?**
* **What role can they play in increasing EC awareness?**

WORK SHEET FOR GROUPS AT DISTRICT LEVEL

District staff	Notes
Curriculum designers	
Professional staff development specialists	
Health education specialists	
Pregnancy or HIV/AIDS prevention specialists	
Support services	
School board	
Other	

WORK SHEET FOR GROUPS AT SCHOOL LEVEL

School staff	Notes
School administrators	
Curriculum specialists	
Health educators	
Other classroom teachers	
Health care providers (e.g., school nurse or school-based health center staff)	
Social workers	
Guidance counselors	
Staff in pregnancy prevention programs	
HIV/AIDS prevention specialists	
Drug/alcohol prevention specialists	
Staff of afterschool programs	
Other	

STEP 4: EDUCATE AND PREPARE ADULTS

How you educate adults in your schools and prepare them to educate students will depend on the "politics" of your school and district. Ideally, all adults in schools should know the basic EC facts and be prepared to answer students' questions and/or direct them to another person or resource. We realize that this is not the reality in every school district.

Distributing written materials about EC is a good place to start. Consider:

* **Distributing letters from a school nurse and/or assistant principal for health explaining why information about EC is important,** with expectations about passing the information on to students.

* **Providing selected staff with written information about EC.** This can be accomplished with brief handouts (such as the fact sheets in Toolbox-2) disseminated at staff meetings or placed in mailboxes.

* **Writing articles for newsletters.** One of the sample articles in Toolbox-5 was written for a newsletter for members of high school HIV/AIDS prevention teams.

While distributing materials is a good first step, short presentations or workshops about EC are more effective because trainers can motivate participants and address perceived barriers to spreading EC information. When planning a training workshop, consider the following: Who should be trained, by whom, and where, and what content should be covered?

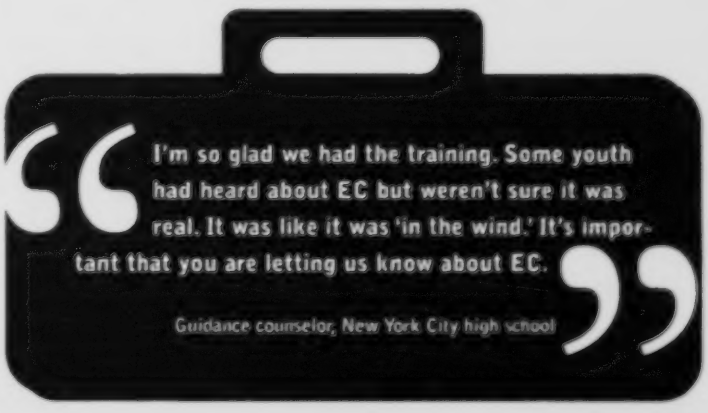
Who Should Be Trained

Who should be trained depends on where you are working. The work sheets in step 3 above specifically help identify people already working in pregnancy prevention. Start with the groups most likely to be receptive to building a constituency in support of EC awareness in the schools. Toolbox-3 has a letter of support from the state department of health that we mailed along with our letter offering EC training to health liaisons in the superintendents' offices in each New York City borough (also in the toolbox). These letters were followed up with (sometimes numerous) phone calls. We had more success when a call was preceded by a contact from an ally inside the system.

Once the key audiences in schools receive training about EC, it might be useful to consider informing *all* adults in the building about EC. After all, students may turn to a particularly "askable" teacher, classroom volunteer, or security officer for advice about personal issues.

The Training Facilitator

Schools and communities often can turn to a variety of sources of trainers who can do an "Introduction to EC" presentation. From the school, consider clinicians, nurses, and health educators who have received EC training. From the community, consider staff from community health centers, local health departments, and medical and nursing schools as

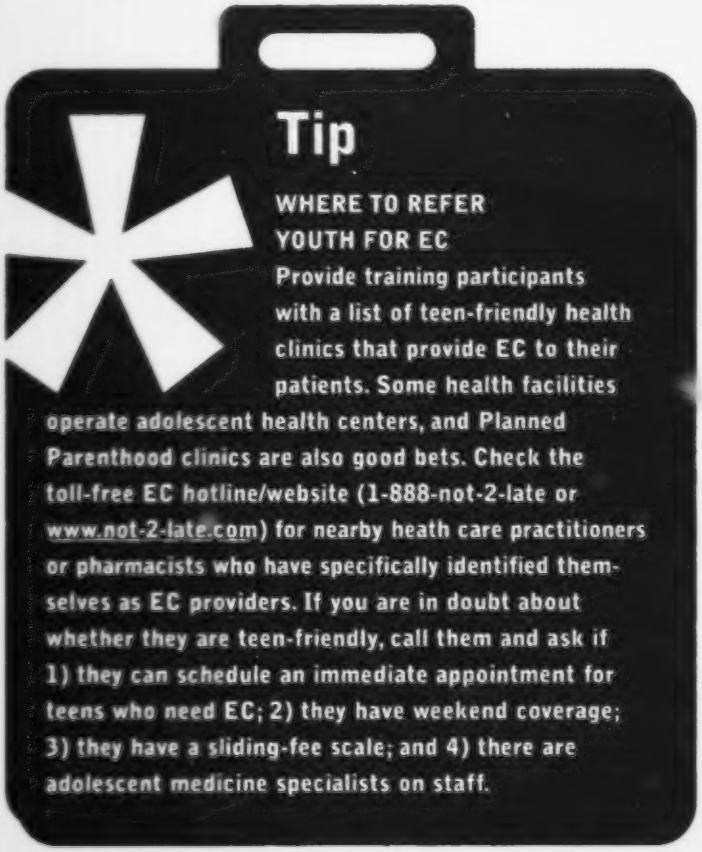

"I'm so glad we had the training. Some youth had heard about EC but weren't sure it was real. It was like it was 'in the wind.' It's important that you are letting us know about EC."
Guidance counselor, New York City high school

well as from pharmacy schools and pregnancy prevention and sexuality education networks.

Pairing a health expert with someone familiar with school policy and practice usually helps motivate trainees to transfer their new knowledge to students. It is also helpful when trainees hear the message from an insider that school staff should educate students to make informed choices after further consultation with a health care provider or pharmacist, and if possible, a parent.

What to Include in Training

When planning a presentation or training, it is important to consider the level of EC knowledge, experience, needs, and perspective of your audience. What are your objectives? What topics must be covered to achieve your objectives? What handouts will be most useful for your audience?



Tip

WHERE TO REFER YOUTH FOR EC

Provide training participants with a list of teen-friendly health clinics that provide EC to their patients. Some health facilities operate adolescent health centers, and Planned Parenthood clinics are also good bets. Check the toll-free EC hotline/website (1-888-not-2-late or www.not-2-late.com) for nearby heath care practitioners or pharmacists who have specifically identified themselves as EC providers. If you are in doubt about whether they are teen-friendly, call them and ask if 1) they can schedule an immediate appointment for teens who need EC; 2) they have weekend coverage; 3) they have a sliding-fee scale; and 4) there are adolescent medicine specialists on staff.

Teaching adults the basics about EC presented in section 2 of this toolkit can take as little as 30 minutes. The "Introduction to EC" presentation, found in Toolbox-3, includes the basic facts about EC, why it is important, information relevant to adolescents, and resources for further information. Didactic presentations can be dry, but entertaining questions and comments at any point can make them more dynamic and relevant. If trainings can be scheduled for more than an hour, there will be time to do a true-or-false quiz, conduct a role play or group discussion, or create an action plan. (See Toolbox-4 for samples.)

Training Logistics

It is convenient to schedule training workshops in conjunction with regular staff meetings or as a workshop on a staff development day. If the trainer is not from your school, you will want to discuss logistical details like number of participants anticipated, AV equipment needs, site and directions, and the type of ID they will need to get in the door. A pre-training planning form in Toolbox-3 can help you and the trainer keep track of these details.

STEP 5: EDUCATE AND INVOLVE STUDENTS

There are numerous ways to inform students about EC. Recognizing that some strategies will be appropriate in your school and others will not, we have listed some of these strategies below. You are sure to have additional ideas. Ideally, districts and schools will make information available to students in a variety of ways, especially proactively.

Disseminate Written Information

Some clever, eye-catching EC materials have been developed for teens and young adults.

There are posters, brochures in various sizes, fact sheets, wallet cards, postcards, and gummed pads where students can tear off a sheet of information. Pictures of two of these materials are included in Toolbox-2, and section 2 lists places to find others.

Display Information About EC

*** Display posters**

The comfort-level of staff in displaying posters in schools largely depends on the school environment. Schools in New York City have displayed EC posters on bulletin boards in hallways, in common seating areas outside guidance counselors' offices, in individual offices, and/or in the nurse's office or school-based health center.

*** Display fact sheets and brochures**

Add EC awareness materials to designated areas where students pick up other health information. School libraries are another place that could have collections of health materials. If your school has a health fair, make sure that EC materials are disseminated by someone knowledgeable about EC, either from within the school or from a health care clinic in the community.

Integrate EC into a Health Curriculum

EC is no more than a new contraceptive method. If you are already teaching comprehensive health education that includes information about condoms and birth control, it will be relatively easy to discuss EC in the context of what you already teach. This is exactly what was done when other methods such as birth control injections (Depo-Provera) and implants (Norplant) became available to the public. If you bring in someone from a CBO to cover sexuality topics, be sure to ask her/him to inform your students about EC.

Tip

BOYS NEED TO KNOW ABOUT EC TOO

Discussions with boys about condoms are perfect opportunities to have the "EC talk." Ask them about their plan of action in the event of slippage, breakage, or nonuse. Boys are often relieved to hear there is a "second line of defense" for pregnancy prevention.[13] In teen sexual relationships, male partners are often older, and girls appreciate their support and assistance in contraceptive choices. Concerns have been raised that males will use condoms less if they know about EC, but research and practical experience suggest this fear is unfounded.[14]

"One student I counseled didn't know EC existed. She seemed relieved that there was an alternative... . She was really upset when she came in and she became more relaxed when she heard about it."

Social worker,
New York City high school

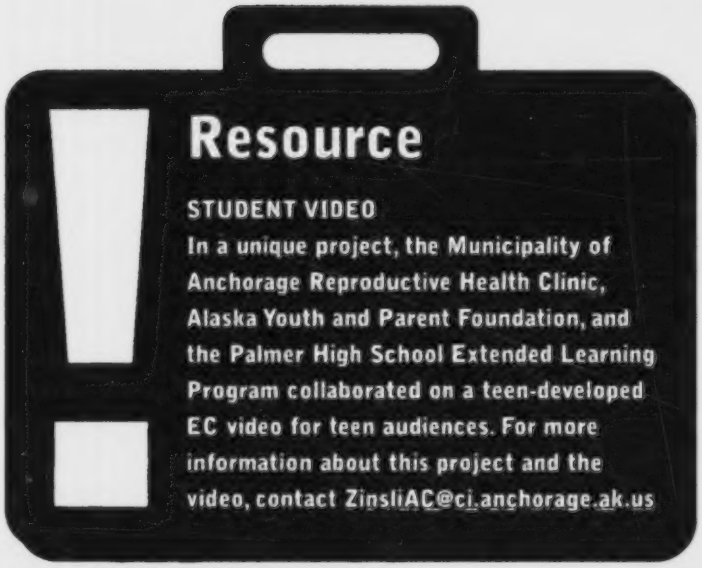
Here are some activities that will build students' skills and bring the topic of EC to life.

* **Explore the facts about EC** with a true-or-false quiz done as a group exercise (see Toolbox-4).

* **Have students develop an EC pop quiz** for their health class (using the lesson plan in Toolbox-4), analyze the results, and report back to the class.

* **Direct students to websites** with EC information (see the list of websites in Toolbox-2) and develop a rating system to assess which sites have the best information for teens.

* **Work with students to create** their own EC health education print or video materials.


Resource
STUDENT VIDEO
In a unique project, the Municipality of Anchorage Reproductive Health Clinic, Alaska Youth and Parent Foundation, and the Palmer High School Extended Learning Program collaborated on a teen-developed EC video for teen audiences. For more information about this project and the video, contact ZinsliAC@ci.anchorage.ak.us

* **Help students develop a brief survey** to test EC knowledge and have them administer the survey to adults in the school, CBO staff, or family members. Ask students to compile the data and compute what percentage of adults knew about EC. On the basis of their findings, students can determine the kind of EC information adults need. Finally, ask students to brainstorm about different ways of informing adults about EC.

Integrate EC into Other Academic Subjects

By incorporating EC into an academic curriculum, students can learn about EC in the context of other academic subjects. This technique has been used effectively in the field of HIV/AIDS prevention. The worksheet in Toolbox-4 suggests ways that information about EC can be integrated into academic subjects.

Counsel Teens

Many teachers and school staff are the trusted adults whom teens rely on for factual information and guidance. Section 2 of this toolkit provides EC information to help you be a valuable resource, especially in advance of a pregnancy scare. Remember, in your role as counselor, you are giving teens the tools to make informed choices within the context of their *own* beliefs and values. Although you may be frustrated when teens make mistakes, remember that everyone does. If they were using condoms that slipped or broke, they were on the right track. Their interest in finding ways to address these mistakes or condom failure shows maturity—they are taking responsibility. As we all know, using condoms and birth control takes skill and practice.

If students have medical questions about EC, encourage them to talk to a health care practitioner or submit a question to the national EC hotline **(www.not-2-late.com)**.

FOOTNOTES

[1] The Alan Guttmacher Institute, 2002, Teen Pregnancy: Trends and Lessons Learned, *Issues in Brief*. Washington, D.C.

[2] U.S. Department of Health and Human Services, June 10, 2002, *Preventing Teenage Pregnancy*, www.hhs.gov/news/press/2002pres/teenpreg.html.

[3] Center for Education Reform, *Education Statistics at a Glance*, http://edreform.com/edstats.htm.

[4] National Association of State Boards of Education,1998, he role of education in teen pregnancy prevention, *Policy Update*, 6(11).

[5] The National Campaign to Prevent Teen Pregnancy, 2001, *Facts and Stats*. Washington, DC: Author.

[6] Greene, Brenda Z., 1998, Adolescent pregnancy prevention: what local school policymakers think about the role of schools, *Updating School Board Policies*, National School Boards Association, 29(6), www.nsba.org/schoolhealth/articles/pregprevent.htm.

[7] Kirby, Douglas, 2001, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, D.C., National Campaign to Prevent Teen Pregnancy. The following five health education programs have been found to delay the onset of sex, reduce the frequency of sex, reduce the number of sexual partners of teens, or increase the use of contraception: Reducing the Risk, Safer Choices, Becoming a responsible Teen, Making a Difference: An Abstinence Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention. Two service learning programs with evidence of success are Teen Outreach Program and Reach for Health.

[8] Kirby, Douglas, *Frequently Asked Questions About Emerging Answers: Research Findings on Programs that Reduce Teen Pregnancy*, http://www.teenpregnancy.org/resources/data/report_summaries/emerging_answers/q&a.asp.

[9] The Kaiser Family Foundation, 2000, *Sex Education in America: Series of National Surveys of Students, Parents, Teachers and Principals. A View From the Nation's Classrooms*, California: Menlo Park. Report Summary available at www.kff.org.

[10] The survey of 503 likely voters was conducted in July 2002 by Peter D. Hart Research Associates for the Reproductive Health Technologies Project. www.backupyourbirthcontrol.org.

[11] Princeton Survey Research Associates (November 19, 2000), The Kaiser/Lifetime vital signs index, survey no. 2, final topline, www.kff.org/lifetime/final_topline.pdf.

[12] National Association of State Boards of Education, 1998, The role of education in teen pregnancy prevention, *Policy Update*, 6(11).

[13] The Kaiser Family Foundation (January 31, 2001), Kaiser Daily Reproductive Health Report, International News, *USA Today*, Reports on availability of emergency contraception in British schools.

[14] The Kaiser Family Foundation, ibid.

[15] The Harlem Health Promotion Center and the Adolescent Initiative Project, Mailman School of Public Health, Columbia University, with the Academy for Educational Development, *Providing Emergency Contraception to Adolescents. A Practical Guide for Clinicians*, 2001, (unpublished).

[16] Carol Roye, 2001, Routine provision of emergency contraception to teens and subsequent condom use: a preliminary study, letter to the editor, *Journal of Adolescent Health*, 28: 165-166.

Section

Emergency Contraception

School-Based Health Centers

Addresses EC issues specific to school-based health centers, including activities to increase EC awareness among health center and school staff.

Section 4 Emergency Contraception & School-Based Health Centers

School-based and school-linked health centers have a unique role to play in increasing EC awareness and access.[1] This section is brief because we assume that most clinicians working with teens in schools are aware of the scope of the problem of adolescent pregnancy in the U.S., as well as in their schools, and are already familiar with EC. This section suggests ways to provide leadership on this issue in your school, backup facility, and community. Toolbox-6 contains sample protocols, consent forms, and other helpful material.

At last count (1998), there were school-based health centers in 579 public schools with high-school-age students in 45 states.[2] These clinics serve thousands of youth, many of whom have no other regular source of health care and no health insurance coverage.

If you oversee and/or provide technical assistance to a number of school-based health centers, you might want to start by assessing the need for EC training and materials. The sample survey in Toolbox-6 was conducted in New York City. It asks staff to estimate the EC knowledge of students and assess the practices of clinic staff with regard to EC. The responses can be useful in determining whether in-service training is warranted and whether staff need EC protocols, outreach materials, and/or written information.

There are a number of useful resources for clinicians who could use more training about EC. The Pacific Institute for Women's Health **(www.piwh.org)** developed a publication specifically for clinicians (see resource on the next page); and online training modules are available from Pathfinder International **(www.pathfind.org)** and the American Pharmaceutical Association **(www.aphanet.org)**.

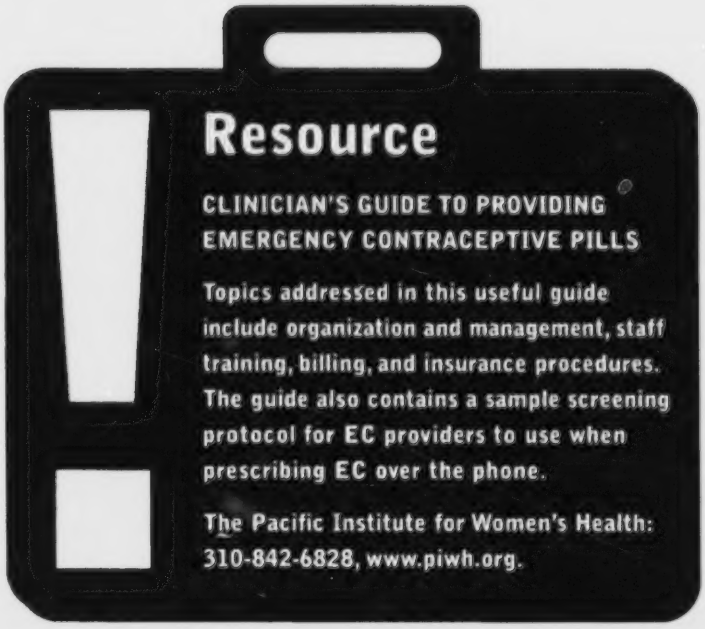
School-based health centers vary greatly in terms of the range of their reproductive health services. In New York City, for example, state policy allows staff to write prescriptions or refer teens to the backup facility for birth control but restricts the clinics from providing contraception on site. However, some school-based health centers in a number of states, such as Oregon, Maryland, and California, can dispense condoms and contraceptives on site. Even if they cannot dispense EC, many clinicians regularly include information about EC as part of their anticipatory guidance to youth who are sexually active or thinking about it.[3] Others wait for students to bring it up. Unfortunately, most patients want their health care providers to initiate these conversations, and the topic is never raised.

Some school-based health centers have developed EC protocols, patient informed-consent forms, and forms for charting progress notes. Samples of materials designed by the Center for Community Health Education, Columbia University, and the Mount Sinai Adolescent Health Clinic in New York can be found in Toolbox-6.[4]

Because of their training, respected status, and organizational independence from school systems, health center staff are natural and strategic leaders for initiatives to increase EC awareness among school staff and students.

For example, if the school's mental health counselor does not know about EC, s/he might not know to immediately send a distraught teen who had recently had unprotected sex to the clinic for EC counseling. Only a few meetings with other school staff is all it takes to assess the information and training needs in a school and map out awareness-building strategies.

Many clinics do not want to call attention to the reproductive health care they provide because they fear that controversy can jeopardize other important health services. You are the best judge of your work climate and what you can do in this climate. The discussion of allies and advisors and school-based issues in the previous section of this toolkit may help.


Resource
CLINICIAN'S GUIDE TO PROVIDING EMERGENCY CONTRACEPTIVE PILLS
Topics addressed in this useful guide include organization and management, staff training, billing, and insurance procedures. The guide also contains a sample screening protocol for EC providers to use when prescribing EC over the phone.
The Pacific Institute for Women's Health: 310-842-6828, www.piwh.org.

ACTIVITIES TO INCREASE EC AWARENESS IN THE HEALTH CENTER AND SCHOOL

The work sheet below offers suggestions about ways that school-based health center staff can increase EC awareness and access in the clinic, the school, an affiliated backup health facility, and the community. You may already be conducting many of these activities and probably have additional ideas. We have left room for other steps you could take to implement these strategies.

Activities to Increase ECP Awareness and Access	Comments
Within the School-based Health Center	
Train nonmedical school-based health center staff about ECPs (e.g., administrative assistants and social workers).	
Develop protocols both for handling requests for ECPs during regular clinic hours and when the clinic is closed.	
Keep supplies of ECPs as well as antinausea medication if your clinic can dispense contraception.	

Discuss EC with female and male patients during routine visits. Hand out fact sheets.	
Give sexually active students ECP prescriptions or pills in advance of need.	
Display ECP posters and brochures.	

In the School	
Meet one-on-one with the principal and other administrators in your school to ensure that they are informed about ECPs. Discuss your ideas about increasing ECP awareness among staff and students.	
Conduct an in-service training with any school staff who might teach, counsel, or talk to students about pregnancy prevention.	
Provide ECP materials for display and dissemination in the school.	
Prepare awareness materials for parents, e.g., a brief article for the PTA newsletter.	
Interest students in working on projects about ECPs, such as writing essays or articles for the school newspaper or conducting student surveys.	
Suggest that ECP information be disseminated at school health fairs and ensure that someone is available to provide accurate answers to students' questions.	
Inform peer health educators in your school about ECPs and help them integrate EC information in discussions of condom use and pregnancy prevention.	

In your Backup Health Facility	
Organize an in-service training for medical and nonmedical staff.	
Ensure that your backup health facility has EC protocols and consent forms.	

Ensure that clerical staff know how to handle calls for EC.	
Develop procedures for handling EC requests after hours, and for walk-ins and call-ins.	
Have supplies of EC as well as antinausea medication in the clinic if your clinic can dispense contraception.	
Display EC information in waiting rooms and examination areas.	
Publicize your EC services. Encourage your facility to be listed on the national EC website: www.not-2-late.com.	

In the Community	
Ensure that local pharmacists are informed about EC and stock EC products.[5]	
In states where pharmacists can provide EC without a prescription, request that local pharmacists send students back to the school clinic or backup clinic for STD testing, pregnancy testing, and follow up.	
Participate in local, state, and national advocacy efforts to increase adolescent awareness and access to EC.	

FOOTNOTES

1 We use the term school-based health center broadly to include school-linked health centers.

2 National Assembly on School-Based Health Care, 2001, *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999*. Washington, DC: author.

3 A recent article in the June 2002 issue of *Transitions*, by Tamarah Moss of Advocates for Youth, reminds us that youth who are gay or questioning their sexual identity may also have heterosexual sex and therefore would benefit from the "EC talk."

4 The protocol and progress notes were reformatted for this toolkit but the content was not changed.

5 A free informational brochure for pharmacists can be obtained from Elayne Archer at the Academy for Educational Development, 100 Fifth Avenue, 8th Floor, New York, NY 10011; earcher@aed.org.

Emergency Contraception

Section

CBOs

Describes steps that CBOs can take to increase EC awareness among adults who work with teens, and teens themselves, both in partnership with schools and in their own community programs.

Section 5 Emergency Contraception & CBOs

Across America, community-based organizations enrich and shape the lives of adolescents. CBOs often promote positive youth development, offer opportunities for recreation and cultural experiences, and build teens' skills and confidence so that they can become self-sufficient, contributing members of their communities. To help youth navigate the numerous health risks they face, CBOs often offer prevention and risk-reduction programming to reduce the incidence of unplanned pregnancy, alcohol and drug use, smoking, and violence.

CBOs have taken on the issue of pregnancy prevention, individually and in coalitions, because they recognize the scope of the problem and the negative impact that early, unintended pregnancy has on families, communities, and the nation. CBO staff are acutely aware of the negative consequences of unintended teen pregnancy described in sections 2 and 3 in a very real and immediate way. These statistics have names and faces among the youth they serve, and CBO staff are often called upon to help these youth with the difficulties they confront.

CBOs address pregnancy prevention in a variety of ways. Some CBOs, in the business of offering health care services, provide counseling and contraceptive services to individuals and educational services to schools and community groups. National programs such as Girls Incorporated encourage their local affiliates to use research-based pregnancy prevention curricula in their programming.[1] Other youth-serving CBOs bring in an outside expert to give the "sex talk." Some CBOs do no formal sex education, but youth workers provide information on sexuality and birth control to teens with whom they have established trusting relationships.

The information in this section is intended to increase EC awareness among those who work with teens and teens themselves. It is intended for staff working in a wide range of CBO settings, including CBOs with clinical expertise in reproductive health; CBOs that offer pregnancy prevention programs in schools; CBOs with no formal sex education programs but that deal with adolescent sexuality in informal ways; national organizations with local affiliates; and teen health and pregnancy prevention coalitions.

All young people have the right to know how to protect themselves from unplanned pregnancy. Teens must have accurate information, the belief that ECPs can benefit them personally, the ability to overcome barriers, and the skills to obtain ECPs if needed. CBOs can increase knowledge about ECPs only if staff members are themselves informed about it. We know, however, that many adults are still uninformed or misinformed about EC.[2]

Increasing awareness in your CBO may be as simple as informing a few key people about ECPs. More up-front preparation may be necessary for organizations that do not generally provide information about preg-

nancy prevention. For organizations in this category, we have outlined, below, five steps to help CBO staff become involved in increasing EC awareness. These are the same as the major steps recommended in section 3 on EC and schools. They include:

* **Establish the need**
* **Lay the ground work**
* **Identify opportunities**
* **Educate adults**
* **Educate and involve teens**

STEP 1: ESTABLISH THE NEED

Before deciding what awareness-building efforts to undertake, it is important to begin with an assessment of the scope of unintended teen pregnancy in the community and an assessment of what is already being done and what gaps remain. The following are questions to consider before you begin.

1. Is teen pregnancy an issue in your area?

If YES: What is the scope of the problem?
What are the issues and concerns?

2. Are there any current efforts in the community to prevent teen pregnancy?

If YES: What are they?
Are they formal or informal?
Who is involved?

From the Field

AN EC STORY

A student with whom I had been working for a couple of months came in to my office on Tuesday, very distraught. She explained that, during the weekend, she and her boyfriend had sex and the condom burst. She said she thought perhaps he had put the condom on wrong or torn it with his nails. The event occurred on Sunday. She was worried when I was not at the school on Monday and wanted to know if she had run out of time for the emergency contraceptive pill. We talked about ECPs and immediately called Planned Parenthood to make an appointment. She went there and told me afterward that she was very relieved. I am thankful that I had the information necessary for her to be able to exercise her option to use ECPs. This particular student is college-bound and having a baby right now would have derailed her future plans.

Teen Choice social worker, New York City

3. Is there any information or education about EC already in the community?

If YES: What CBOs are involved?
Are the educators adequately trained?
Could more staff use training?
How is EC information disseminated?
Who does the information reach?
Who doesn't it reach?
What needs are not being met?

If your CBO is already involved in pregnancy prevention, you more than likely have data about local teen pregnancy rates at your fingertips. If you do not, there are some key places to find these data that are especially accessible over the Internet. A list of some of these websites can be found in section 2.

STEP 2: LAY THE GROUNDWORK

Early in your planning of activities to increase EC awareness, lay the groundwork by establishing the importance of the issue for the key stakeholders such as the CBO board and administration, clarifying issues of consent and confidentiality, and preparing for difficult questions.

Establish the Importance

People who are not well informed about teen pregnancy need to know about the number of teen pregnancies in the community every year and the fact that 85% of them are unplanned. They should also understand that half of unplanned pregnancies among adolescents could be avoided with EC and that this, in turn, could prevent half of all abortions (since half of unintended pregnancies end in abortion).[3] Section 2 also provides some compelling information about the health, social, and economic impacts of unintended pregnancy on teens, their babies, and the community.

Clarify Issues of Consent and Confidentiality

CBO staff will need to know their organization's policies and procedures for counseling and referring youth who are sexually active and/or who think they may be pregnant. Staff may also want to know about federal and state laws addressing consent and confidentiality protections if teens are referred to a health care provider. In section 2 we note that all teens have the legal right to consent to confidential contraceptive services and testing and treatment of HIV and other STDs, if they receive services at programs participating in the federal Title X family planning program. Information about specific state laws pertaining to adolescents' rights to confidential health care can be found on the Alan Guttmacher Institute website: **www.agi-usa.org**. Local experts can be found at your ACLU chapter and in clinics specializing in adolescent health care.

Prepare for Difficult Questions

You may have personal concerns about EC. In addition, your fellow staff, the parents of the youth you deal with, and other community members may have reservations about EC and adolescents. Anticipating questions about EC and preparing your responses in advance will help you be a more effective advocate for increasing EC awareness. As stated previously in this toolkit, questions may be difficult because they are technical and complex, or they may involve differing religious and moral viewpoints. Having trained groups with varying levels of experience with adolescent reproductive health, we are aware that many adults have concerns, especially when they work with "high risk" youth. Staff fear that teens who learn about EC will "misuse" the method or over-rely on it, leading to increased risk of sexually transmitted infections. They fear that boys and young men will be more coercive about having sex without condoms. Preliminary evidence shows that these fears are unwarranted; we have addressed some of these questions in sections 2 and 3.

It is helpful for those who may face difficult questions to work with others in a meeting or as part of an EC training workshop to generate a list of difficult questions and practice responding to them.

Resource

INFORMATION ABOUT MINORS' RIGHTS
ACLU Reproductive Freedom Project: 212-549-2633

STEP 3: IDENTIFY OPPORTUNITIES

Who in the organization should know about EC? The answer will depend on your CBO's mission and size, the professional background of staff, and the services currently offered. Use the work sheet below to identify those needing EC information and the type of information they might need.[4] Start with staff who are most important in terms of building EC awareness in your CBO. You may have to do some investigation to find out how informed about EC these individuals or groups are. Informal conversations, interviews, and surveys can help determine the type of EC information staff may need. The work sheet below will help you chart who needs what in your CBO. Pages 67 to 69 contain brief descriptions of what might be covered under the topics listed, as well as helpful resources.

CBO WORK SHEET: WHO NEEDS TO KNOW ABOUT EC AND WHAT THEY NEED TO KNOW

Groups	Basic EC Facts	Advanced EC Information	Consent and Confidentiality	Accessing EC	Effective Counseling	Responding to Difficult Questions	Other
Board of directors							
Executive director							
Medical director and practitioners							
Advisory board							
Health educators							
Youth workers							
Clerical staff							
Public relations staff							
Volunteers							
Fundraisers							
Chief financial officer							
Parents							
Other							

STEP 4: EDUCATE AND PREPARE ADULTS

The steps you take to educate adults and prepare them to educate teens will depend on your work context. Ideally, all adults should know the basic EC facts and be prepared to answer a young person's questions or direct them to another person or resource. We understand that this is not the reality in every context.

Distributing written materials about EC is a good place to start. Consider:

* **Providing staff with written materials about EC.** This can be accomplished with brief handouts (such as the information sheets in Toolbox-2 or others available on the Internet) disseminated at staff meetings or placed in mailboxes.

* **Distributing letters from a doctor, nurse or trusted staff member** about why information about ECPs is important, with the expectation that the information will be passed on to teens.

* **Writing articles for newsletters.** One of the sample articles in Toolbox-5 was written for a newsletter for members of high school HIV/AIDS prevention teams.

Distributing materials is an important first step, but short presentations or workshops about EC are even more effective. When time is limited, a basic presentation with questions and answers may be a good place to start. If there is more time, training workshops can cover the basic EC facts, as well as more advanced EC information and information about confidentiality, access, and effective counseling. Workshops that allow time for discussion are generally more valuable to participants. Topics for training are discussed below.

Basic Information about EC

Teaching adults the basics about EC presented in section 1 of this toolkit can take as little as 30 minutes. The "Introduction to EC" presentation, found in Toolbox-3, includes the basic facts about EC, why it is important, information relevant to adolescents, and resources for further information. This presentation is very straightforward and should be supplemented with informational materials for participants. For trainings that are over an hour, there will be time to incorporate role-playing and group discussions, or to create action plans. (See Toolbox-4.)

Advanced Information About EC

Once staff members understand the basic EC facts, they may be interested in other aspects of EC. The scientific literature from the United States and other countries where EC has been in use for decades addresses topics such as the mechanism of action and comparisons of combination pills (estrogen and progestin) and progestin-only pills. New studies are coming out about the efficacy of EC up to 120 hours (5 days) after unprotected sex and the value of the second dose. Studies

Resources

SOURCES FOR EC TRAINERS

Members of your pregnancy prevention coalition

Members of local sexuality education networks

Planned Parenthood education departments

Faculty and students from medical, nursing and pharmacy schools

Public health departments

are being conducted to evaluate the use of more effective methods of birth control after EC use and use patterns when EC is provided in advance.

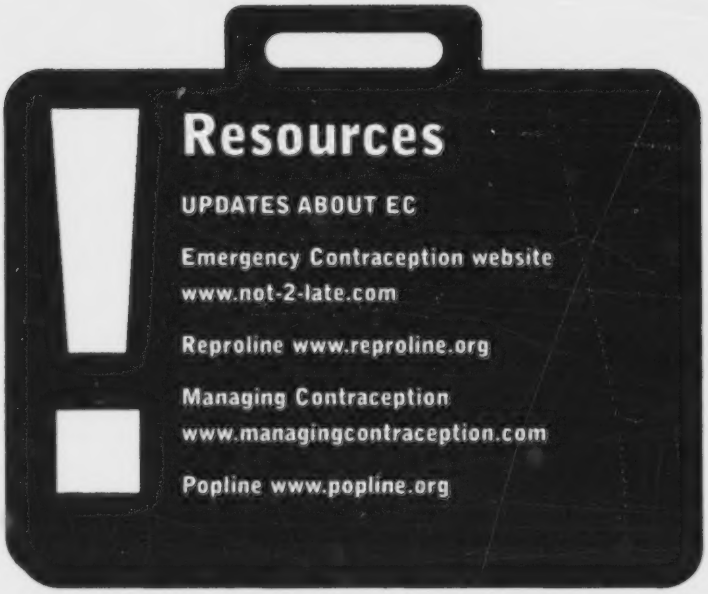
Information about Confidentiality and Access

A training session on confidentiality might cover:

* **How to initiate conversations with teens about their right to confidential care**
* **How to discuss with a teen if and how a parent or other responsible adult will be involved in their care**
* **How to discuss confidentiality protections with a parent**
* **How to encourage a teen to involve a parent, if appropriate**[5]

CBO staff will want to know where to refer clients who request EC and do not have an established relationship with a provider. It's a good idea to compile a list of teen-friendly health providers and pharmacists in your community with hours of operation and instructions for accessing ECPs if the office is closed. It is also helpful to find out about patient fees. If your CBO does not have an existing relationship with a health care provider, consider an adolescent or public health clinic or the nearest Planned Parenthood clinic (which you can find by calling **1-800-230-PLAN**). Another source of providers is the national EC hotline (**1-888-NOT-2-LATE** or **1-866-EN-TRES-DIAS**) or the website (**www.not-2-late.com**), which organizes its list of providers by area code.

In Alaska, California, New Mexico, and Washington, consumers can obtain ECPs directly from a participating pharmacist. The **www.not-2-late.com** website lists the names of participating providers, and in California, consumers can find a participating pharmacist on the Internet—**www.ec-help.com/Pharmacy Locations.asp**—or by calling **510-272-0150**. Other states are moving to replicate this model, and it is possible that ECPs will be available on pharmacy shelves without a prescription in the near future. Because the field is changing very quickly, we recommend that you consult websites for the latest information about EC access.



Effective Counseling

Counseling helps people make and act on choices about sexuality-related matters.[6] Thus, inherent in counseling is the responsibility of the counselor to be nonjudgmental and nondirective. However, counseling teens about reproductive health and EC is a sensitive matter. Low comfort-levels and personal values and attitudes often muddy the counseling process, particularly for CBO staff members who do not regularly work with youth on reproductive health issues. Even if they are well informed about the EC basics, staff may not have clarified their own values regarding EC. Any adult in a position to provide EC information to a teen should know her/his limits and avoid personal bias.

If a staff member feels judgmental or compelled to direct a teen in what to do, s/he should acknowledge that bias and consider referring the teen to someone who feels able to counsel her without bias. In addition to confronting and dealing with personal values, other counseling skills involve the counselor's recognizing opportunities for discussing EC, knowing how to initiate a conversation on EC, and being a good listener.

Whatever the specific content of the training for CBO staff, it is helpful to bring training participants together several weeks after the training to debrief about their experience and problem-solve about any obstacles they encounter. Once CBO staff have the basic EC information, and feel comfortable doing so, they may consider posting signs or wearing buttons while at the workplace that invite teens to "Ask me about EC." In this way, if individuals choose to ask, the conversation has already been started.

Tip

ATTRIBUTES OF TEEN-FRIENDLY SERVICES

- Services are confidential and affordable.
- Staff are trained in adolescent care.
- Hours and appointments are convenient for teens.
- Age-appropriate services include identification and treatment of sexual abuse.
- A full range of medical and mental health services is available.

Tip

PROVIDING NONJUDGMENTAL, NONDIRECTIVE COUNSELING

Professionals who recognize that they cannot offer EC information without imposing their biases, should refer the teen to a person or organization that can, as quickly as possible. One way to help a client decide for herself when your values differ is to say: "Some people believe . . . Other people believe . . . I happen to believe . . . . You must decide what you believe with the help of people close to you, especially your parents or another responsible adult."

STEP 5: EDUCATE AND INVOLVE TEENS

There are many ways to inform teens about EC; the right ones will depend on your context. Ideally, CBOs will make information available to teens in a number of different ways, especially preventively. These include displays of outreach materials, integrating EC information in pregnancy prevention programming, and training teens as EC peer educators and advocates.

Display EC Outreach Materials

Displaying posters, handouts, and brochures is a relatively easy way to increase EC awareness in a CBO. Print materials can be convenient conversation-starters for youth and a reminder for staff to mention EC when talking with teens. Be sure you have your CBO's approval beforehand.

You can reproduce the informational materials in Toolbox-2 or obtain other free EC materials from some of the places listed on the **www.not-2-late.com** website. Additional resources are listed in section 2 and Toolbox-2.

Integrate EC Information into Pregnancy Prevention Programming

This is easy for organizations already offering birth control information to youth because EC is no more than a new method teens need to know about. We have included two lesson plans for youth in Toolbox-4. The first lesson reinforces EC knowledge through an activity in which teens decide whether statements are true or false. The objectives of the second lesson, using role-play scenarios, are to reinforce EC knowledge and strengthen communication skills.

Train Peer Educators About EC

Many CBOs train peer educators to provide information about various aspects of reproductive health. Peer educators have been especially effective in getting the message out about HIV/AIDS and STDs prevention. If your organization trains peer educators, equip them with EC information. For example, if they are talking to peers about using condoms, they could add:

> "If you are having heterosexual sex and the condom breaks or slips, you need a back-up plan: To prevent pregnancy, the female partner can take emergency contraceptive pills within 5 days (120 hours). She should call her health care provider immediately about emergency contraceptive pills and both partners should schedule an appointment to get tested for HIV and other STDs."

Toolbox-3 contains a copy of a PowerPoint presentation on EC developed for peer educators by the Mailman School of Public Health, Columbia University. The main points covered are the number of teen pregnancies in the U. S. and reasons for unintended pregnancies; awareness that pregnancy prevention methods have been used throughout history; current myths about prevention; how pregnancy occurs and how EC works; when to use EC and why it does not cause abortion; and potential side effects. Contact Renee Cohall (rmc49@columbia.edu) to obtain the electronic file.

Help Teens Become EC Advocates

Teens can play an active role in advocating for EC access, informing other adults and teens about EC, and increasing EC availability. Use the ideas below to brainstorm ways you can help teens become EC advocates.

* **Organize to display EC information at the CBO** and pass out pamphlets informing youth about EC at appropriate events (e.g., health fairs).

* **Find out where teens can get EC in your community.** Assess whether these locations are "teen friendly" (see the tip: Attributes of Teen-Friendly Services earlier in this section). Write a letter to health care providers suggesting ways to better meet the needs of teen patients.

* **Find out whether local pharmacies stock emergency contraception products** (PREVEN® or Plan B®). If they don't, develop a plan of action to encourage them to do so.

* **Find out if local pharmacists can make EC available to women without a prescription.** If they are not participating in the state program (Alaska, New Mexico, California, Washington), encourage them to do so and suggest that they contact the state pharmacists' association to learn more about pharmacy access programs.

* **Prepare and send a letter to the editor of the local newspaper about EC.**

* **Ask your local TV station to air an EC public-service announcement.** Several PSAs developed by Advocates for Youth and PATH can be found on their websites: **www.advocatesforyouth.org/news/psa** and **www.path.org/resources/ec_tools.htm**.

* **Write a letter to your state legislators stating your views about EC access for teens,** if there is pending EC legislation.

Special Issues for National Affiliates with Local CBOs

National youth-serving organizations can demonstrate their support for increasing EC awareness by letting their affiliates know that they support activities to increase awareness and access at the national and local levels. They can also help ensure that their local affiliates have the EC information and resources they need to achieve the organization's EC awareness goals. National organizations can:

1. **Make sure that key staff are fully knowledgeable about EC,** including executive directors, medical directors, and directors of curriculum development and training.

2. **Ensure that any health education curricula recommended to affiliates contain updated information about EC.** If not, amend the curricula or contact the publisher asking that EC information be included in any new editions. Send affiliates written information to supplement curricula that have not yet been revised.

3. **Include EC updates on the agendas for training workshops for master trainers and direct service staff.** Supply lists of resources so that they can obtain the latest information about EC. (See section 2.)

4. **Write an article on EC for the organization's newsletter or website to inform affiliates about EC and also encourage local staff to disseminate information to other staff and youth.** Newsletter articles about EC written by AED and included in Toolbox-4 can be used as samples.

5. **Explore ways the organization can become involved in EC policy at the national and/or state levels.** One such opportunity is involvement in the Back Up Your Birth Control campaign: check out **www.backupyourbirthcontrol.org** for more information. Other possibilities include taking action in support of policies concerning access to EC (e.g., contraceptive coverage by health insurance, access to EC information and pills for survivors of sexual assault, and direct EC access through pharmacists). To find out about how you can become involved, contact the Reproductive Health Technologies Project at **www.rhtp.org/ec** or Advocates for Youth at **www.advocatesforyouth.org**. An advocacy project taking place at the state level is described in the next section.

Community Teen Health Coalitions

Emergency contraception is especially relevant to the work of community coalitions concerned with teen health and sexuality. Teen pregnancy prevention is most successful when it becomes a priority for an entire community—increasing awareness about EC is just a small part of this picture. Many communities already have organized to promote teen health (e.g., forming coalitions to focus on prevention of teen pregnancy or HIV/STDs). Coalitions are good places to identify the CBOs that might be willing and able to spread the word about EC.

Youth-serving CBO organizations can play an important role in advocacy at the state level. Population Services International (PSI) is conducting a project designed to organize community organizations to educate state legislators and health care policymakers and administrators about the importance of teens' confidential access to EC to prevent unintended teen pregnancy. PSI's goals are to safeguard the legal protections for confidential access and to encourage institutional policies that provide timely access to EC. PSI is in the

process of developing a video and toolkit for use in these efforts. (For more information, contact **www.psi.org**.)

A pregnancy prevention or teen health coalition can organize and educate allies in the community to answer medical questions about EC and respond to difficult questions involving attitudes and beliefs. Key categories of stakeholders might include experts (such as the public health department, health practitioners, and pharmacists), opinion leaders (press, local officials, and clergy), and parents. If your community does not have a pregnancy prevention or teen health coalition, pull together an ad hoc EC committee and share responsibility for building awareness within these groups.

Tip
Put EC on the agenda of your next teen pregnancy coalition meeting. Find a speaker from among your members and exchange information on training resources and outreach materials. Share this toolkit!
RESOURCE FOR PREGNANCY PREVENTION COALITIONS
National Campaign to Prevent Teen Pregnancy
1776 Massachusetts Ave., NW, Suite 200
Washington DC 20036
www.teenpregnancy.org 202-478-8500

FOOTNOTES

1 http://www.girls-inc.org. Girls Incorporated is a national, nonprofit youth organization providing research-based informal educational programs to millions of American girls, particularly those in high-risk, underserved areas.

2 Kaiser Family Foundation, 1997, *Emergency Contraception, Is the Secret Getting Out?*

3 Hatcher RA, Trussell J, Stewart F, Howells S, Russell C, Kowal D, 1995, *Emergency Contraception: The Nation's Best-Kept Secret*, Atlanta: Bridging the Gap Communications, Inc.

4 Keep in mind that people with these job titles may also need to know about EC because they are sexually active themselves, they have adolescent children and nieces/nephews of their own, or they are the people sought out by neighbors and their children's friends for information about health and sexuality.

5 Mount Sinai Adolescent Health Center, New York Civil Liberties Union Reproductive Rights Project and Physicians for Reproductive Choice and Health, January 2000, *Minors' Rights to Confidential Reproductive Health Care in New York State*.

6 Spain J, 1988, *Sexual, Contraceptive, and Pregnancy Choices*. New York: Gardner Press, p. 4.

Section

Measuring Progress

Explains how evaluation can enhance efforts to increase EC awareness and access in schools and CBOs and suggests some basic, low-cost program evaluation activities.

Section 6

Measuring Progress

Evaluating efforts to increase EC awareness in schools and CBOs is important for the following reasons.

1. **It requires the statement of objectives and planned activities in clear, measurable terms.**

2. **It indicates exactly what was accomplished and for whom** (e.g., number of people trained or number of brochures disseminated to different types of schools) to see if objectives were met.

3. **It can determine the short- and long-term impact** (e.g., changes in knowledge, attitudes, or behaviors) on the groups reached by project activities, such as adults who work with teens or teens themselves.

4. **It can identify the strengths and weaknesses** of implemented strategies for increasing EC awareness so that efforts can be redirected to improve effectiveness.

5. **It provides valuable information for reports** to the school board or administrators or the CBO executive director or board of directors.

6. **It documents achievements** for the organization that funds the program and provides a basis for requests for continued or new support.

Evaluations can vary in terms of complexity and cost. Initial steps for any evaluation are deciding on the most important questions about the project that the evaluation should answer and determining how to work within the confines of available resources (e.g., money, time, person power) for undertaking the evaluation. This section suggests some simple ways to evaluate EC awareness and access efforts. The toolbox contains sample forms that can be adapted for this purpose, and these may be sufficient in many situations.

Organizations considering a more extensive evaluation should probably team up with an expert to help design and conduct a rigorous study. That expertise may already exist on staff, at the central office (school district), or at the national headquarters (CBOs). If not, possible places to find experts include an organization that provides technical assistance to local nonprofit organizations, a nearby college or university, an evaluation organization, or an individual consultant. There are pros and cons to using each of these types of evaluation experts, including cost and availability. It is wise to interview a few individuals to determine if they understand your needs, if the approach recommended sounds reasonable, and if you feel compatible with the person with whom you will work most closely.

EVALUATION STEPS

There are four basic steps in undertaking an evaluation: define the project; determine the purpose of the evaluation; select the data collection methods and collect the data; and analyze data and report the findings.

1. Define the Project

The first step in any evaluation is to define, as specifically as possible, what the project intends to accomplish (objectives) and, the proposed methods and activities for achieving the objectives.

2. Determine Evaluation Questions

Next, list the questions that the evaluation can realistically answer. Most projects begin with a process evaluation, which is the type of evaluation that counts what a project did and compares findings to what a project aimed to do (the objectives). The other alternative—outcome evaluation—seeks to determine whether the program was responsible for any changes detected in the target audience. For example, how many unintended pregnancies were averted because of the project's EC activities? Since outcome evaluations are generally more difficult and too costly for most projects (they require a substantial budget and the services of a trained evaluation expert), they will not be discussed here.

3. Select Data Collection Methods and Collect Data

The next step is to determine the most appropriate methods for obtaining the answers to these questions (e.g., observation, documentation, surveys, personal interviews, and/or focus groups). The proposed data collection methods should be discussed with some project staff who will be involved in the evaluation to ensure they are realistic.

Assuming that most organizations choose to conduct a process evaluation, the following are examples of some key evaluation questions and suggestions about methods that can be used to easily answer them.

How many people did I train and what were their jobs?

A simple attendance form can be used to collect this information (see Toolbox-7). Ask participants to sign the attendance form and tally the number of people trained. The evaluators can use the information about participants' job titles or roles in the organization or school to determine whether the training reached the intended audience. Collecting participant contact information allows for follow up with participants to determine if they used the information they received during the training session after returning to work. Reconnecting with those trained offers an opportunity to help them overcome barriers they may have encountered.

How many schools/classes/CBOs did I contact?

Keep a data base or list of every school and CBO contacted by the project (see Toolbox-7). If the project's objective is to reach all the schools in a particular geographic area, begin by listing all the targeted schools in the first column, then add columns for the different kinds of information required for the project and evaluation. Make entries to the data base every time the project provides services to keep track of the people contacted, where they work, and the type of services provided (e.g., training, technical assistance, and/or materials).

To gauge project progress, determine the percentage of targeted schools/classes reached,

or assess where the requests originated. This will begin to create a picture of how far the EC message has spread and where. Findings may indicate that the project has successfully reached certain places and not others, thereby helping project staff set new targets for outreach.

What type of EC materials were requested and disseminated?

Counting the number of EC educational materials (pamphlets, posters, etc.) disseminated is an easy way to measure progress in raising EC awareness. Use a written or electronic data base to keep track of all requests for materials (see Toolbox-7) and numbers of materials you distribute in other ways. These data can inform project staff about the most popular materials. (For example, AED's EC awareness project in New York City learned from this tracking system that the number of Spanish brochures requested quickly exceeded original expectations, which had been based on the percentage of Hispanic students in the high school population.) Finally, a materials data base can help the project determine when supplies are running low and need to be reordered (see Toolbox-7). The figure below depicts the possible headings for an EC materials chart or data base and how it might be used.

EC MATERIALS CHART

CBO/School	Date	Recipient/ Contact Information	Posters	Pamphlets (English)	Pamphlets (Spanish)
High School for the Arts	10/2/02	Jane Pallet 212-333-4567	5	250	75
YMCA of Chicago	10/4/02	Jim Bigheart 312-444-8910	2	25	25
Total			7	275	100

Did the training increase EC knowledge? Were training participants satisfied?

Comparing participants' knowledge, attitudes, and comfort before and after a training session is a commonly used method to obtain feedback about the quality of training. If available training time is short, administer the post-training survey only, but ask participants for perceptions both before and after the training. For example, "On a scale of 1 to 5, where 1=very uninformed and 5=very informed, how informed were you about EC before the training? After the training?"

The results of an evaluation survey like the one in Toolbox-7 will suggest areas where the training is successful and where it could be strengthened. One direct way of obtaining this information is to ask participants about their satisfaction with various aspects of the training (e.g., content, presentation format, materials, and facilities) and to make specific recommendations about changes in these aspects. Also, an item on the survey can ask participants to suggest other groups they think would profit from the EC training. These suggestions can be fed back to the program staff on an ongoing basis.

Did the training participants spread the word about EC?

Following up with training participants by telephone several weeks after the training is a way to discover whether they are passing along to adults and/or youth the EC information provided during the training. A telephone interview can also ask for feedback about their experience with the resources or EC materials they used (e.g., what materials are working best in various settings). (See Toolbox-7 for sample follow-up telephone interview protocols.)

Are youth more informed about EC and are they asking for prescriptions?

If one of the objectives of the EC project is to increase awareness in a school or CBO setting, then one of the evaluation research questions might ask whether youth/students/staff are more informed about EC as a result of project efforts. To do this, school health teachers might add a few questions about EC to another survey they may be conducting on related topics. Questions can be adapted from the Facts about Emergency Contraception—True or False activity in Toolbox-4. School-based health centers or pregnancy prevention programs might want to track increases in requests for EC information or prescriptions over time, beginning immediately before the start of EC training and awareness efforts.

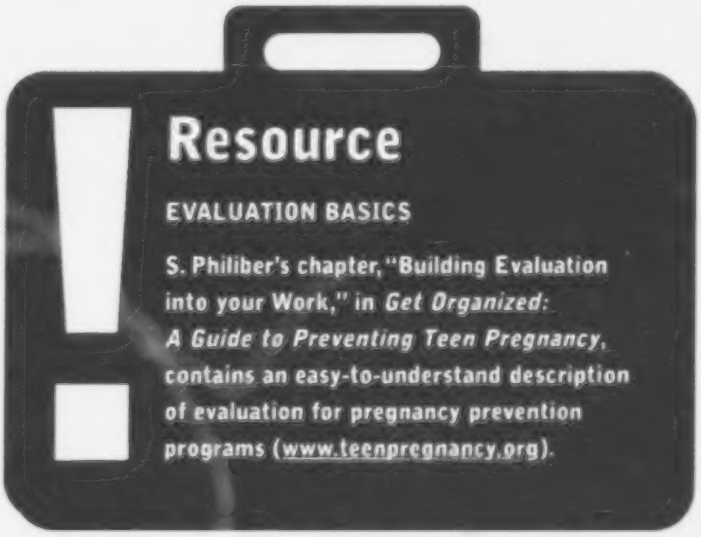
How many unplanned pregnancies were avoided?

This is the big question everyone will want to know. However, measuring events that are prevented is tricky, and the research required is impractical for schools and CBOs. Instead, we generally suggest that projects consider collecting case studies about teenagers who have been able to obtain EC and possibly avoid an unwanted pregnancy. These case studies, combined with the findings about the materials distributed, number of people trained, number of schools and CBOs involved, and level of EC awareness among youth and staff, will provide valuable information for assessing project efforts and informing others about project accomplishments.

4. Analyze Data and Report the Findings

The evaluation methods suggested here do not require complicated analyses. In general, most analyses will involve calculating frequencies (e.g., total numbers) for the whole population and possibly subgroups. A discussion with those who conducted various components of the project can provide insights about the findings, an opportunity for reflection, and brainstorming about next steps. Determine in advance the audiences you want to reach with the evaluation findings and prepare reports or presentations that will capture their attention. In this regard, a short executive summary is helpful if the evaluation findings are contained in a long report. Some audiences might prefer a graphically appealing one- or two-page summary sprinkled with quotes from the target group.

In summary, evaluation should be a part of all EC awareness and access projects and can be a valuable source of information at all stages of a project; feedback can be used for making improvements along the way. We hope that this section of the toolkit has demystified evaluation and convinced you of its importance in fostering EC awareness among youth and adults in schools and CBOs.


Resource
EVALUATION BASICS
S. Philiber's chapter, "Building Evaluation into your Work," in *Get Organized: A Guide to Preventing Teen Pregnancy*, contains an easy-to-understand description of evaluation for pregnancy prevention programs (www.teenpregnancy.org).

We wish you the best with all your efforts to help adolescents avoid unplanned pregnancies, enjoy health and safety, and achieve their life's ambitions.

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Toolbox

1 EMERGENCY CONTRACEPTIVE PILLS

* EC Pills and Doses
* Dial EC

2 FACT SHEETS ABOUT EC AND OTHER SOURCES OF MATERIALS

* Preventing Pregnancy *After* Unprotected Sex: Fact Sheet for Adults
* Emergency Contraception Fact Sheet for Teens
* Annotated List of EC Resources on the Internet
* Health Websites for Teens with EC Information
* Sample of AED's EC Educational Materials

3 TRAINING RESOURCES

* Sample Letter from the State Department of Health in Support of Staff Training and Materials Dissemination
* Sample Letter to School Administrator Offering EC Training and Materials
* Materials and Training Order Form
* Pre-training Planning Form (for recording training content and logistics)
* EC Training for Adults (PowerPoint presentation)
* EC Training Scenarios (of situations involving EC and teens for small-group discussions)
* EC Training Workgroup Questions (to help participants articulate the relevance of EC to their work and plan ways to increase EC awareness)

4 SAMPLE EC LESSONS FOR TEENS

* EC Training for Teens (PowerPoint presentation)
* Facts about Emergency Contraception—True or False
* Answers to Facts about Emergency Contraception—True or False
* Emergency Contraception Role Plays
* Suggestions for Integrating EC into Academic Curricula

5 SAMPLE NEWSLETTER ARTICLES ABOUT EC

* Simkin, L, 2001, "Preventing Pregnancy After Unprotected Sex – Helping You Answer Your Students' EC Questions," HIV/AIDS Team Newsletter, NYC, unpublished.
* Simkin L, 2001, "Preventing Pregnancy AFTER Unprotected Sex," *Joining Hands*, 1:3 and 6.

6 RESOURCES FOR SCHOOL-BASED HEALTH CENTERS

* EC Survey for School-Based Clinic Health Practitioners
* School-based Clinic Policy and Procedures on EC
* Emergency Contraception Protocol
* EC Patient Informed Consent Form—English and Spanish
* EC Reminder Sheet—English and Spanish
* EC Progress Notes

7 MANAGEMENT INFORMATION AND EVALUATION TOOLS

* Emergency Contraception Training Participant List
* Training Evaluation Form
* School/CBO Contact Database
* Materials Database
* EC Training Follow-up Telephone Interview: School Personnel
* EC Training Follow-up Telephone Interview: CBO Staff

8 THE NEW YORK STORY: A CASE STUDY OF *YOU CAN'T TEACH WHAT YOU DON'T KNOW*, AED's Project to Increase EC Awareness in NYC Public High Schools and CBOs.

Toolbox 1

Emergency Contraception Pills

* EC Pills and Doses
* Dial EC

EMERGENCY CONTRACEPTIVE PILLS AND DOSES

TYPE OF PILL	FIRST DOSE Number of pills to swallow as soon as possible.	SECOND DOSE Number of pills to swallow 12 hours after first dose.
Plan B®	1 white pill	1 white pill
PREVEN®	2 blue pills	2 blue pills
Ovral	2 white pills	2 white pills
Ogestrel	2 white pills	2 white pills
Low-Ogestrel	4 white pills	4 white pills
Levlen	4 light-orange pills	4 light-orange pills
Levora	4 white pills	4 white pills
Lo-Ovral	4 white pills	4 white pills
Nordette	4 light-orange pills	4 light-orange pills
Tri-Levlen	4 yellow pills	4 yellow pills
Triphasil	4 yellow pills	4 yellow pills
Trivora	4 pink pills	4 pink pills
Alesse	5 pink pills	5 pink pills
Levlite	5 pink pills	5 pink pills
Ovrette	20 yellow pills	20 yellow pills

Hatcher RA, Nelson AL, Zieman M, Darney PD, Creinin MD, and Stosur HR, *A Pocket Guide to Managing Contraception, 2001-2002*. Tiger, Georgia: Bridging the Gap Foundation, 2001.

DIAL EC

Forty-seven Planned Parenthood clinics currently respond to requests for EC over the telephone. Callers do not have to be previous patients of the clinic. Trained counselors go through a protocol with the caller, ask about her usual method of birth control, and provide information about STDs. If the caller meets the screening criteria, a clinician associated with the hotline writes a prescription for ECPs and faxes it to a local pharmacy that carries ECPs.

	PLANNED PARENTHOOD AFFILIATES WITH DIAL EC
Alaska	Planned Parenthood of Alaska
California	Planned Parenthood of Mar Monte
	Planned Parenthood of Golden Gate
	Planned Parenthood of Santa Barbara, Ventura & San Luis Obispo Counties
	Planned Parenthood of Shasta-Diablo
Connecticut	Planned Parenthood of Connecticut
Delaware	Planned Parenthood of Delaware
Georgia	Planned Parenthood of Georgia
Illinois	Planned Parenthood of East Central Illinois
	Planned Parenthood of Springfield Area
Indiana	Planned Parenthood of North Central Indiana
Iowa	Planned Parenthood of Greater Iowa
Kentucky	Planned Parenthood of Lexington
Massachusetts	Planned Parenthood of Massachusetts
Michigan	Planned Parenthood of North Central Indiana
	Planned Parenthood of Mid-Michigan
	Planned Parenthood of Northern Michigan
	Planned Parenthood of South Central Michigan
Montana	Intermountain Planned Parenthood
New Jersey	Planned Parenthood of Mercer Area
New York	Planned Parenthood of Buffalo & Erie County
	Planned Parenthood of Southern Tier
	Planned Parenthood of Tompkins County
	Planned Parenthood of Niagara County
	Planned Parenthood of Mohawk Hudson
North Carolina	Planned Parenthood of Orange and Durham Counties
Oklahoma	Planned Parenthood of Central Oklahoma
Pennsylvania	Planned Parenthood of North East Pennsylvania
	Planned Parenthood of Susquehanna Valley
Texas	Planned Parenthood of Cameron & Willacy
	Planned Parenthood of Texas Capital Region
	Planned Parenthood of West Texas
Utah	Planned Parenthood of Utah
Washington	Planned Parenthood of Central Washington
	Planned Parenthood of Inland Northwest
	Planned Parenthood of Western Washington
Wisconsin	Planned Parenthood of Wisconsin

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Toolbox 2 Fact Sheets

about EC and other Sources of Materials

* Preventing Pregnancy *After* Unprotected Sex: Fact Sheet for Adults
* Emergency Contraception Fact Sheet for Teens
* Annotated List of EC Resources on the Internet
* Health Websites for Teens with EC Information
* Sample of AED's EC Educational Materials

PREVENTING PREGNANCY *AFTER* UNPROTECTED SEX!

Keeping adolescents safe and healthy today is a challenge! High rates of unplanned adolescent pregnancy, HIV, and other sexually transmitted diseases indicate that youth are having difficulties protecting themselves. Many do not prepare for sex, especially if they are just becoming sexually active, and some are forced to have sex. Others have problems accessing condoms and birth control, and many who try to protect themselves need practice before becoming competent, consistent users. For example, condoms often slip or break and girls may forget to take their pills or get another shot. You are the people that youth trust with questions and concerns about many important aspects of their lives—including unintended pregnancy. **That's why you need to know about Emergency Contraceptive Pills (ECPs) a way to prevent unintended pregnancy *after* sex.**

THE FACTS

* **Emergency contraceptive pills are concentrated doses of ordinary birth control pills that can prevent pregnancy.** They generally require two doses. The first dose should be taken within **120 hours after unprotected sex**, and the **second dose is taken 12 hours later**. The FDA has approved two ECP products, PREVEN® and Plan B®. In addition, the FDA has approved the use of specific doses of 11 types of regular birth control pills for emergency contraception.

* **ECPs are safe.** ECPs have been used by women outside the U.S. for 30 years. Because only a small number of pills need to be taken for a short period of time, ECPs can be used by women who cannot take birth control pills on a regular basis. Using ECPs will not affect a woman's ability to get pregnant in the future. If taken by mistake by an already pregnant woman, ECPs will not harm the developing fetus. ECPs are considered so safe that the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and other groups have petitioned the FDA to make ECPs available in pharmacies over the counter.

* **ECPs are effective.** Effectiveness in preventing pregnancy ranges from 75% - 89% when taken within 72 hours, and ECPs are more effective the sooner they are taken after unprotected sex. ECPs are recommended for emergency use only, because other contraceptive methods are more effective for preventing pregnancy, and ECPs do not protect against HIV/AIDS or other STDs.

* **ECPs will not cause an abortion.** ECPs are not the same as the abortion pill (RU486/mifepristone), which will end a pregnancy up to 7 weeks after a woman's last menstrual period. Depending where a woman is in her menstrual cycle, ECPs act by delaying or inhibiting ovulation, and/or altering transport of egg or sperm, and/or by changing the lining of the uterus, thereby preventing implantation—the accepted medical definition of pregnancy.

* **ECPs are inexpensive—they cost from $20-25.** ECPs are available at many health clinics and all Planned Parenthoods, with fees often based on ability to pay. Prescriptions for ECPs and medical visits are covered by Medicaid and some private insurance companies. ECP use is strictly confidential and parental consent is not necessary to receive a prescription or purchase the pills. Many healthcare providers give women an ECP prescription to have on hand in case of emergency.

Want to Know More?

Visit *www.not-2-late.com*, *www.advocatesforyouth.org*, *www.ppnyc.org*, or call 1-888-NOT-2-LATE (1-888-668-2528).

EMERGENCY CONTRACEPTION FACT SHEET FOR TEENS

* **Emergency Contraceptive Pills (ECPs) can reduce your chances of getting pregnant** if taken within 5 days (120 hours) after unprotected sex.

* **ECPs generally require two doses.** Take the first dose within 120 hours of unprotected sex and the next dose 12 hours later. (Plan B® can be taken in one dose—2 pills.)

* **ECPs are safe and effective.** However, you may experience side effects such as nausea or vomiting.

* **ECPs are not as effective as other forms of birth control for regular use.** They do not protect against STDs or HIV. See your doctor or health care provider about more effective contraceptive options.

* **ECPs do not cause abortion.** If you are already pregnant, they will not disrupt that pregnancy. ECPs will not harm the developing fetus.

* **Many teenagers turn to their parents for help in difficult situations.** For those teens who can't, other adults may provide confidential counseling and access to ECPs.

* **ECPs are available only by prescription.** In some states like Alaska, Washington, California, and New Mexico, pharmacists can provide EC without a visit to the doctor. In any state, call 1-888-NOT-2-LATE to find a doctor or pharmacist near you.

* **Office visits are not always required to obtain ECPs.** After asking you some questions over the phone, some physicians will call in a prescription to a pharmacist without first requiring an office visit. Some Planned Parenthood Clinics may also offer a "Dial-EC" service. Most physicians will want you to come in for STD testing and other contraceptive counseling. They will also want to see you if you do not get your period in the next three weeks.

* **The cost of ECPs varies.** There are many free and low-cost options for obtaining ECPs. Fees charged at family planning clinics usually depend on your ability to pay. Public and private health insurance programs like Medical and Medicaid may cover ECPs, and some states have programs for people without health insurance (Child Health Plus in NY and FamilyPACT in CA) that will pay for ECPs. The average retail price of the pills is $20-$25, and there may be an additional fee for the visit to your health care provider.

ANNOTATED LIST OF EC RESOURCES ON THE INTERNET

*** Advocates for Youth**
www.advocatesforyouth.org

Creates programs and advocates for policies that help young people make informed and responsible decisions about their reproductive and sexual health. Advocates for Youth provides information, training, and strategic assistance to youth-serving organizations, policy makers, youth activists, and the media in the United States and the developing world, and has a substantial amount of emergency contraception educational materials.

*** Alan Guttmacher Institute**
www.agi-usa.org

A nonprofit organization focused on sexual and reproductive health research, policy analysis and public education. AGI is an excellent resource for state and national data on teen sexual health issues.

*** American Society for Emergency Contraception**
ASEC

A voluntary collaboration of organizations that promotes the option of emergency contraception for women.

*** Association of Reproductive Health Professionals**
www.arhp.org

A nonprofit, national medical organization that educates health providers, their patients and the public about important reproductive health issues, including contraception, sexually transmitted diseases, HIV/AIDS, menopause, urogenital infections, cancer prevention and detection, abortion, sexuality, and infertility. AHRP offers an on-line EC Continuing Medical Education course.

*** Back up your Birth Control**
www.backupyourbirthcontrol.org

A campaign to help make emergency contraception (EC) more effective by putting it in the hands of women – before a crisis occurs. The website contains an on-line toolkit for groups working to spread the word about EC. It also provides outreach materials for a wide range of audiences, including women, health care providers, advocacy organizations, and the media.

*** Consortium for Emergency Contraception**
www.cecinfo.org

Provides information, and resources about EC, advocates for expanded access, assists in planning, and facilitates information sharing. The consortium works to expand women's access to EC in developing countries.

*** Emergency Contraception Website**
www.not-2-late.com and
Hotline 1-888-Not-2-Late *or* **1-888-668-2528**

Provides a wealth of information about emergency contraception derived from the medical literature and contains a national directory of clinicians self-identified as EC providers. The website also contains lists of pharmacists participating in pharmacy access partnerships in California, Washington and Alaska. The site is in English, Spanish, and French.

*** Family Health International**
www.fhi.org

A nonprofit organization that improves reproductive and family health around the world through biomedical and social science research, innovative health service delivery interventions, training, and information programs. FHI's emergency contraception materials include fact sheets, reports of current research, and training presentations.

*** Healthfinder**
www.healthfinder.gov

A resource for health information documents produced by federal agencies for consumers.

*** JHPIEGO**
www.jhpiego.org

A nonprofit organization affiliated with Johns Hopkins University that trains health care professionals about contraceptive methods. The website has an EC training module and tools for trainers. The May 2002 issue of *Contraceptive Technology Update Trainer News* is devoted to EC.

*** Journal of American Medical Women's Association**
http://jamwa.amwa-doc.org/vol53/toc53_5.html

Published an Emergency Contraception Supplement in 1998 (vol. 53, no. 5), which is available online, free.

*** National Campaign to Prevent Teen Pregnancy**
www.teenpregnancy.org

Seeks to reduce the rate of teen pregnancy by one-third between 1996 and 2005. The website has a variety of teen pregnancy prevention materials and research for teens, parents, professionals, policymakers, and the press.

*** National Family Planning and Reproductive Health Association**
www.nfprha.org

A nonprofit membership organization that works to improve access to comprehensive family planning and reproductive health care services and to support reproductive freedom for all. The website has a thorough fact sheet on EC along with links to related policy and legislative issues. The website outlines multiple avenues for political activism and includes an advocacy toolkit.

*** Program for Appropriate Technology in Health**
www.path.org

Works to improve the quality of reproductive health services worldwide. PATH played a significant role in the Washington State EC access project, and it has downloadable EC client brochures in 13 different languages (search for EC Materials for Diverse Audiences).

*** Physicians for Reproductive Choice and Health**
www.prch.org

Works to enable concerned physicians to take a more active and visible role in support of universal reproductive health; has published downloadable information cards called Minors' Rights to Confidential Reproductive Health Care available for Georgia, New Jersey, New York and Pennsylvania.

*** Planned Parenthood Federation of America**
www.plannedparenthood.com

Has a great deal of emergency contraception information in both English and Spanish, including fact sheets; information about reproductive rights, including access to EC in emergency rooms; and a list of EC resources.

*** Population Council**
www.popcouncil.org/faqs/emergencycontraception.html

An international, nonprofit institution that conducts research on three fronts: biomedical, social science, and public health. A search for "emergency contraception" produces fact sheets and updated research on EC.

*** Reproductive Health Technologies Project**
www.rhtp.org

Works to advance the ability of every woman to achieve full reproductive freedom with access to the safest, most effective, and preferred methods for controlling her fertility and protecting her health. The website provides a thorough overview of emergency contraception, including facts, media coverage, hotline information, and efforts to bring EC over-the-counter.

*** Resource Center for Adolescent Pregnancy Prevention**
www.etr.org/recapp

Provides practical tools and information to effectively reduce sexual risk-taking behaviors. Teachers and health educators will find up-to-date, evaluated programming materials to help with their work with teens. ReCAPP serves as a bridge between front-line educators and the researchers who are analyzing how educational and youth development programs can reduce the rate of unintended teen pregnancy.

*** Sexuality Information and Education Council of the United States**
www.siecus.org

Develops, collects, and disseminates information, promotes comprehensive education, and advocates the right of individuals to make responsible sexual choices. The SIECUS website has a bibliography on the topic of emergency contraception and teen sexuality issues.

HEALTH WEBSITES FOR TEENS WITH EC INFORMATION

* **Advocates for Youth**
  www.advocatesforyouth.org

* **Go Ask Alice**
  www.goaskalice.columbia.edu

  Columbia University, Health Education Program. Targeting a college audience, it offers answers to questions on a wide array of health topics including contraception and sexual health.

* **Ask Beth**
  www.ppsp.org/askbeth/askbeth.html

  Planned Parenthood of Southeastern Pennsylvania

* **Dr. Drew**
  www.drdrew.com

  Drew Pinsky, M.D.

* **I Wanna Know**
  www.iwannaknow.org

  American Social Health Association

* **It's Your (Sex) Life**
  www.itsyoursexlife.org

  Kaiser Family Foundation

* **KidsHealth**
  www.kidshealth.org/teen

  Nemours Foundation, Center for Children's Health Media

* **Sex, Etc.**
  www.sxetc.org

  The Network for Family Life Education, State University of New Jersey at Rutgers publishes this print and web-based newsletter written by teens for teens.

* **Teen Growth**
  www.teengrowth.org

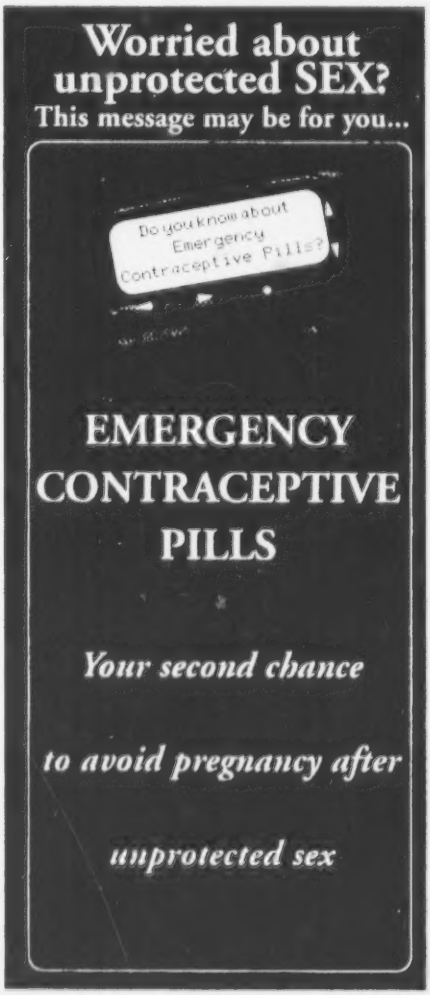
  A team of pediatricians

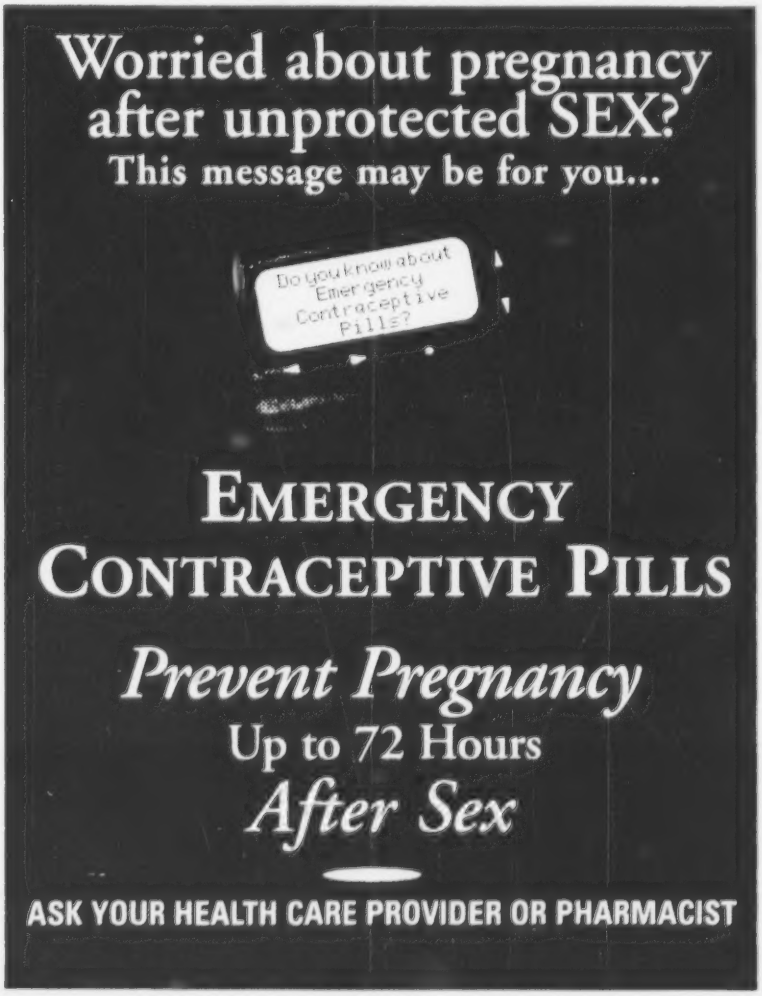
* **Teenwire**
  www.teenwire.org

  Planned Parenthood Federation of America. Addresses a variety of teen issues, and interactive contraceptive information.

SAMPLE OF AED'S EC EDUCATIONAL MATERIALS

AED's teen-friendly EC materials include a poster; brochures and wallet cards in (English and Spanish); dj cards (5x7); and tear-off pads (50 sheets – 3.5x5). The poster and English brochure are shown below. In addition, AED has pads (50 sheets – 8.5x11) of easy to understand ECP instructions developed for teens and an informational booklet for pharmacists that includes a section on teen issues. Contact Linda Simkin at 212-243-1110 or **lsimkin@aed.org**.


Worried about unprotected SEX?
This message may be for you...
Do you know about Emergency Contraceptive Pills?
EMERGENCY CONTRACEPTIVE PILLS
Your second chance
to avoid pregnancy after
unprotected sex


Worried about pregnancy after unprotected SEX?
This message may be for you...
Do you know about Emergency Contraceptive Pills?
EMERGENCY CONTRACEPTIVE PILLS
Prevent Pregnancy
Up to 72 Hours
After Sex
ASK YOUR HEALTH CARE PROVIDER OR PHARMACIST

Toolbox 3 Training Resources

* Sample Letter from the State Department of Health in Support of Staff Training and Materials Dissemination
* Sample Letter to School Administrator Offering EC Training and Materials
* Materials and Training Order Form
* Pre-training Planning Form (For recording training content and logistics)
* EC Training for Adults (PowerPoint presentation)
* EC Training Scenarios (of situations involving EC and teens for small-group discussions)
* EC Training Workgroup Questions (to help participants articulate the relevance of their EC work and plan ways to increase EC awareness)

Dear

Thank you for your recent letter regarding the Emergency Contraception Project at the Academy for Educational Development. I want to express my strong support for your work to increase access, awareness and appropriate use of emergency contraception by adolescents.

We agree that it is essential that providers of health care to adolescents be well informed about emergency contraception. I am enclosing lists of the school-based health centers and community-based adolescent pregnancy prevention projects in New York City, and I hope that many of them will take advantage of the training and materials you are offering.

Please keep me informed of the progress of this important project.

Sincerely,

Director
Adolescent and School Health

February 7, 2003

Ms. Adele Administrator
Manhattan Superintendent's Office
122 Amsterdam Ave.
New York NY, 10002

Dear Mr. Administrator:

The latest data for Manhattan indicates that there were 4,105 births to girls 15-19 in Manhattan. At a rate of 111.6/1000, over one in 10 Manhattan teenagers become pregnant each year! I'm sure you will agree that students cannot reach their academic potential if they are pregnant or worried about pregnancy. A new method of **pregnancy prevention**—Emergency Contraception (EC)—has been approved by the FDA, and the Academy for Educational Development (AED) has been providing information about it to health educators and guidance counselors in New York City high schools for the past 2 years. We have provided training for APs for Health and Physical Education in the Bronx, BASIS, and Brooklyn superintendencies. We have also conducted a TOPPP training for guidance counselors, and we have trained community-based organizations that work in the schools. We would like to offer this **free** assistance to appropriate staff in your schools.

Our trainings and materials stress these four major points:

- It is possible to prevent a pregnancy from occurring for up to 120 hours after unprotected intercourse.

- Emergency contraceptive pills are concentrated doses of hormones found in regular birth control pills; the FDA has recently approved two new products specifically for emergency contraception.

- Emergency contraception is not RU486 (the abortion pill). Emergency contraception *prevents* a pregnancy; it does not terminate an existing pregnancy.

- Doctors consider emergency contraception safe and effective and have prescribed it to victims of sexual assault for 30 years in this country.

Students are going to be asking their teachers about EC in response to the recent mass media campaigns about EC in the city. We can help prepare school staff to provide accurate and helpful information. I look forward to exploring the possibilities for providing training for appropriate staff. Please contact me if you are interested in our free assistance.

Sincerely,

MATERIALS AND TRAINING ORDER FORM
YOU CAN'T TEACH WHAT YOU DON'T KNOW PROJECT

I would like the following:
(Please check all that apply)

☐ **A training workshop for CBO staff about emergency contraception**

☐ **Written information about emergency contraception**

☐ **A list of web-based resources about emergency contraception**

☐ **FREE informational materials designed for teens (see samples attached)**

ITEM	QUANTITY
Brochures (English)	
Brochures (Spanish)	
Posters	
DJ Cards (5x7)	
Pads (50 sheets – 3.5x5)	

☐ **Other (please explain)** _____

NAME _____ TITLE _____

SCHOOL _____

ADDRESS _____

_____

TELEPHONE _____ E-MAIL _____

Academy for Educational Development
100 Fifth Avenue, 8th Floor
New York, NY 10011
212-367-4562 (phone)
212-627-0407 (fax)

PRE-TRAINING PLANNING FORM

1. Name of organization: _____

2. Address:

3. Name of Contact(s):_____ phone:_____ email:_____

4. How referred:_____

5. Day and date for training: _____ Time: _____

6. Amount of time available for training: _____ minutes

7. Number of attendees expected: _____

8. Training setting: ❑ staff meeting ❑ ECP only ❑ part of larger training

9. AV equipment: ❑ PowerPoint: computer & projector ❑ Overhead projector ❑ None

10. Audience:
- ❑ school administrators/teachers
- ❑ guidance counselors
- ❑ social workers
- ❑ health care providers/clinicians
- ❑ other: _____

11. Prior knowledge about ECP: ❑ High ❑ Medium ❑ Low

Main goal for an ECP training:

12. Main points to cover during training:

13. Directions to training site:

14. Special instructions:

15. Handouts:
- ❑ Samples of EC materials for students in appropriate languages
- ❑ List of adolescent-friendly health care providers
- ❑ EC policies from national health or educational associations
- ❑ Articles about EC from newspapers or magazines
- ❑ Lists of EC resources on the web
- ❑ Written district/school policies pertinent to EC
- ❑ Handout of the slide presentation
- ❑ State policies about minor's rights to confidential health care
- ❑ Evaluation survey

EMERGENCY CONTRACEPTION AND ADOLESCENTS

Linda Simkin, Mphil
Kari Nelsestuen, MA
Stacy Silverstein, MHS

Academy for Educational Development
100 Fifth Avenue, 2nd Floor
NY, NY 10011
(212) 243 -1110
www.aed.org

Adapted from PATH (2000) *Emergency Contraception: Diverse Audiences Toolkit* Seattle, Washington

1

Why is Emergency Contraception Needed?

In 1998, there were 30,000 teenage pregnancies in New York City.

Most were unintended.

EC could reduce these pregnancies by half.

2

Reasons for Unintended Pregnancies

- No use of contraception
- Misuse of contraception
- Contraceptive failure

3

What are Emergency Contraceptive Pills? (ECPs)

- A contraceptive method commonly known as the "morning after pill" that can prevent pregnancy up to 3 days after unprotected sex.
- ECPs are pills that contain the same hormones as oral contraceptive pills (Estrogen and/or Progestin) but in higher doses.

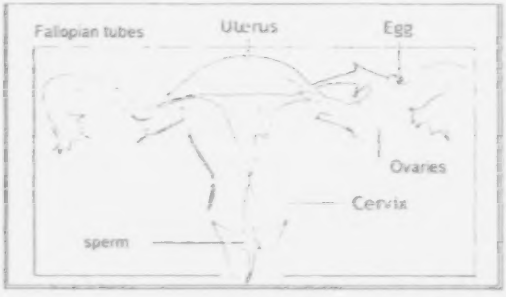
4

When does pregnancy occur?

- **Myth:** Pregnancy occurs instantly after sex.
- **Fact:** It can take up to 6 days after sex for an egg to be fertilized and implanted in the uterus.
- **Opinion:** The medical definition of pregnancy begins with implantation. For some religions, pregnancy begins with fertilization.

5

Female Reproductive Tract



How do ECPs Work?

3 ways ECPs Can Prevent Pregnancy *After* Sex

- ECPs may prevent or delay the release of an egg
- ECPs may inhibit the movement of egg or sperm through the fallopian tubes
- ECPs may alter the uterine lining so a fertilized egg cannot implant

7

3 Types of ECPs

- Specific doses of 11 brands of oral contraceptive pills (Estrogen and/or Progestin)
- Preven - Estrogen and Progestin
- Plan B - Progestin-only

For now, ECPs are available in NY by Prescription only

8

ECPs DO NOT cause abortion

- ECPs cannot dislodge an established pregnancy
- ECPs do not affect fetal development
- ECPs are **not** the same as **RU-486**

9

Who can use ECPs?

- Any woman who has had unprotected sex within the last 3 days
- Women who cannot use OCs on a regular basis

Who should not use ECPs?

- Pregnant women - because ECPs will not end the pregnancy

10

How to use ECPs

- Take **2** doses of ECPs **12** hours apart up to **3** days after unprotected sex

Side effects

- Some women experience nausea and vomiting when they take ECPs
  - For Preven and OCs, 50% of women become nauseous and 20% vomit
  - For Plan B, 23% of women become nauseous and 6% vomit
- The next menstrual period may be early or late

11

ECPs are safe

- Small amounts of estrogen and progestin in short period of time
- ECPs do not affect future fertility

How much do ECPs cost?

- With insurance: $5-10 co-pay
- Without insurance: $18-35
- Visits fees may be additional

12

ECPs are Effective

After Unprotected Sex -For Emergency Use

- Preven: 75%
- Oral Contraceptives for EC use: 75%
- Plan B: 89%

Methods for Protected Sex-For Consistent Use

- Condoms 97%
- Oral Contraceptive Pills: 99%
- Diaphragm: 97-98%
- Depro-Provera: 99%

13

Why are ECPs only for emergencies?

- Lower effectiveness rates compared to other contraceptive methods
- DO NOT protect against HIV/STDs
- More side effects than other contraceptives
- Higher costs compared to methods like condoms and birth control pills

14

New York Laws

- Adolescents have the legal right to confidential counseling about contraception
- Parental consent is not required in order for adolescents to receive ECPs
- Available by prescription-only

Clinic Policy

- Pregnancy tests are not required, however, some clinics perform them
- Experts do not recommend pelvic exams for an ECP visit

15

Ways to Improve ECP Awareness

- Inform youth about ECPs before an emergency
- Encourage them to have an Rx for ECPs in advance
- When adolescents seek ECPs, use the opportunity to counsel them about future contraception options
- Discuss ECPs with other adults who work with adolescents (HIV/AIDS Team, SPARK, social workers)

16

Key messages for adolescents

- ECPs can be used to prevent pregnancy within 3 days (72 hours) of unprotected sex
- ECPs do not cause abortion
- ECPs are safe and effective
- Adolescents have the right to confidential counseling and access to ECPs
- ECPs are not as effective as other forms of birth control for regular use

17

For More Information on EC

- EC Hotline
  - 1-888-NOT-2-LATE (1-888-668-2528)
- EC on the internet
  - http://not-2-late.com
  - http://plannedparenthood.org/ec
  - http://www.ppnyc.org
  - www.ec4u.org
  - www.advocatesforyouth.org
- ECP Dedicated Products
  - www.PREVEN.com
  - www.go2planb.com

18

EMERGENCY CONTRACEPTION TRAINING SCENARIOS

Instructions: Please work in small groups. Choose ONE of the following scenarios. Take a few minutes to brainstorm about each of the questions. Write down your answers and designate one person to share them with the larger group. Ask if others have any additional suggestions or comments.

1. **An adolescent confides in you that his/her best friend (age 15) had unprotected sex last night and is worried about being pregnant.**

   A. Would you tell them about EC? Why? Why not?
   B. If you would tell them about EC, what are the key facts you would want to convey?
   C. Where would you suggest they obtain EC? Why?
   D. Can you think of any advice you would give about getting EC quickly? What suggestions for follow-up might you make?

2. **A student you have been working with tells you that she is not ready to become pregnant a second time. She tells you about a sign she saw about the morning-after pill and comments that she does not believe that abortion would be a good option for her.**

   A. What would you tell her about EC?
   B. How would you respond to her concerns about abortion?
   C. How would you suggest that she consider a regular method of birth control or getting a prescription for EC as a back up method?

3. **While having lunch with some of the teachers in your high school, one mentions that a student has told her that she is pregnant. She is frustrated that "nothing can be done to prevent teen pregnancy." How can you use this as an opportunity to inform your colleagues about EC?**

   A. How could you begin talking about EC?
   B. Are there adults in your school who should know about EC but do not?
   C. What are some ways to inform them? What might you need to help increase EC awareness among these adults?
   D. What, in turn, might they need to inform students about EC?

EMERGENCY CONTRACEPTION TRAINING
WORKGROUP QUESTIONS

1. Is the topic of emergency contraception relevant to my work?
If yes, how would I explain to a colleague the relevance of ECPs and the work I do?

2. What action steps can I take to increase student AWARENESS about ECPs?

A. What do I need to help me increase student awareness?

B. What barriers am I likely to encounter (e.g. personal or organizational)? What would help me overcome these barriers?

3. What steps can I take to increase student ACCESS to ECPs?

A. What do I need to help me increase student access to ECPs?

B. What barriers am I likely to encounter? What would help me overcome these barriers?

4. Are there other adults in my school or school community who need to know more about ECPs? What steps can I take to increase their ECP awareness?

A. What do I need to help me increase adult awareness about ECPs?

B. What barriers am I likely to encounter? What would help me overcome these barriers?

Toolbox 4

Sample EC Lessons for Teens

* EC Training for Teens (PowerPoint presentation)
* Facts about Emergency Contraception—True or False
* Answers to Facts about Emergency Contraception—True or False
* Emergency Contraception Role Plays
* Suggestions for Integrating EC into Academic Curriculum

Emergency Contraception (EC) What Teens Need To Know

Renee Cohall, ACSW
Alwyn Cohall, M.D.
Marjorie Momplaisir, MPH
Dawn Dickerson, MPH
Harlem Health Promotion Center
Mailman School of Public Health

Teen Pregnancies

Over 1 million teens become pregnant each year

85% of these pregnancies are unplanned

Teen parents are less likely to graduate high school, go to college or earn adequate salaries

Teen parents are more likely to require support from public

Why Do Teens Get Pregnant?

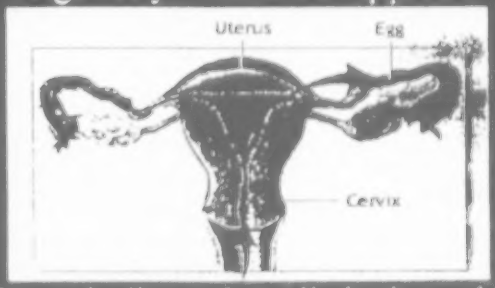
May underestimate their chances of getting pregnant

May feel self-conscious about buying contraceptive products

May have less access to confidential medical care

May be reluctant to use contraceptive methods because of fear of side effects

Pregnancy - How it happens...



Sperm are released into woman's vagina. If ovulation has occurred an egg has been released, a mature egg may be fertilized by a sperm. The fertilized egg must then travel to the uterus and implant for pregnancy to begin.

When can a Girl get Pregnant?

Sperm may live for 5 days inside a woman's body –

Highest risk for pregnancy is 2 days before and 2 days after ovulation (egg released)

BUT – there is a chance you can still get pregnant anytime during the month!

Teens often have irregular cycles – can't tell when they will ovulate

To Prevent an Unintended Pregnancy

Women will do almost anything.....

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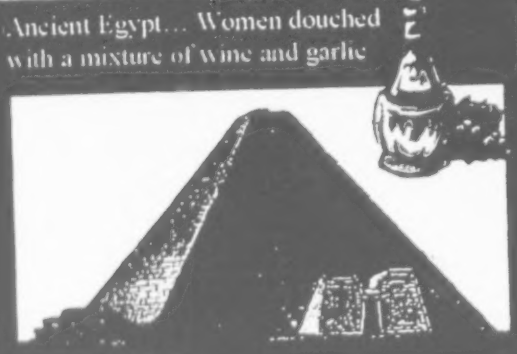
EC History (1): Things that didn't work

Ancient Egypt… Women douched with a mixture of wine and garlic



EC History (2): Things that didn't work

Modern day comparison… Women douching with Coca-cola or Malta.

What else have you heard?

Drinking herbal teas
"Sperm Busters"
Jumping up and down
Taking a bath

What If....

There was a medication that could be taken in an " emergency" (after unprotected sex) that would safely, effectively reduce chances for having an unintended pregnancy?

Would you be interested in learning more about it???

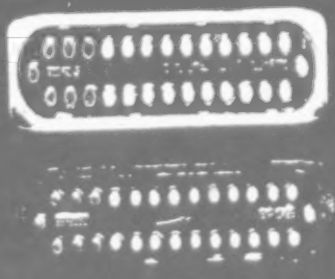
Emergency Contraception

Emergency contraceptive pills are special types of birth control pills taken within 72 hours after unprotected sex.

Can reduce the risk of pregnancy by 75% to 88%

Source: Trussell 1998; WHO 1998; Trussell and Ellertson 1999

Emergency Contraceptive Pills



Ovral

Wyeth

Lo/Ovrel

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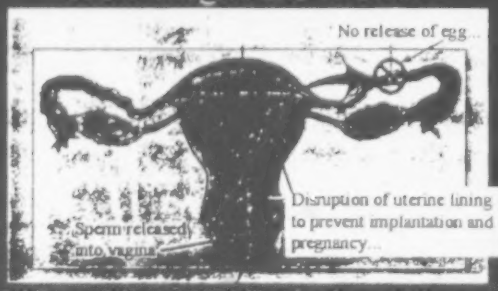
How might EC work?



- Inhibit or delay OVULATION (release of the egg).
- Prevent implantation by disrupting the uterine lining.

Traditional EC Effectiveness:

100 women have unprotected sex during ovulation

8 will become pregnant without emergency contraception

Only 2 [illegible] become pregnant if they use EC

Emergency Contraception Can Also Be Called.....

EC

ECP

Morning After Pill

Why Use EC?

Birth Control sometimes fails (ie: condoms can slip off or break, birth control pills can be forgotten or lost...)

People don't always use protection

Women can be forced to have sex

If more people used EC...

There would be fewer unintended pregnancies

There would be fewer abortions

EC - Is Not New...

In the 1960's EC was used mostly in Emergency Rooms to prevent rape victims from pregnancy

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EC – Is Not New...

It has been used by college women for over 30 years

Has been used by women (and teenagers) in other countries all over the world

But...

Teenagers have not heard about EC

Doctors have been reluctant to talk about it

No ad campaigns targeted to young people

Why?

Some Doctors have difficulty talking to teens about sex

Some Doctors are concerned that teens will abuse EC and not use regular birth control

Some Doctors are concerned about long term safety

Why?

Only recently has EC been approved by the FDA

No "dedicated" product until recently (Plan B, Preven)

Fear of controversy

EC ? RU486

(the abortion pill mifepristone)

Definition of Abortion

(American College of Obstetricians and Gynecologists)

Pregnancy occurs after a fertilized egg has implanted onto the lining of the uterus and grows into an embryo

An abortion - is a procedure that removes the attached embryo from the wall of the uterus

EC – How it Works

Since EC prevents release of the egg or prevents the fertilized egg from attaching to the uterus. IT DOES NOT CAUSE ABORTIONS

How to Use EC

Take 2 doses 12 hours apart

Choose a good time to take the first dose (if you take the first dose at 2:30 p.m. the next dose will have to be taken at 2:30 in the morning)

So, try to take it when it is most convenient for BOTH doses (for example: 8PM and 8AM)

Most Common Side Effects

Nausea
- may occur after either dose of medication
- tends to last for 2 days or less

Vomiting
- once in awhile

Reducing Side Effects

Medication is available to reduce nausea and vomiting if administered _-1hr before EC use

Less nausea with Plan B

FAQs

Where do I get it?

Can I get it before I need it?

Do my parents need to know?

How much does it cost?

Will it prevent me from having kids in the future?

I have diabetes, can I still use EC?

BEST COPY AVAILABLE

FACTS ABOUT EMERGENCY CONTRACEPTIVE PILLS (ECPS) TRUE OR FALSE

	True	False	Don't Know
1. Emergency contraception is a type of birth control that can be used after a person has sex.			
2. There are several brands of emergency contraception pills on the market.			
3. ECPs can only be obtained from a doctor.			
4. Emergency contraceptive pills are 100% effective in preventing pregnancy when taken within 3 days of unprotected sex.			
5. Emergency contraceptive pills are expensive.			
6. ECPs can cause dangerous side effects.			
7. ECPs cannot cause an abortion.			
8. Emergency contraception may be harmful to a developing fetus.			
9. Emergency contraceptive pills protect against sexually transmitted infections, including HIV.			
10. A teenager has the legal right to obtain emergency contraception without her parent's permission.			
11. It is a good idea for young women to have a prescription for emergency contraceptive pills on hand in case they need it.			

This quiz and the answers on the following page, were developed by Advocates for Youth, Inc., Washington, DC. Some questions and responses were revised by AED. The original questions and lesson plan can be found on **www.advocatesforyouth.org**.

ANSWERS TO FACTS ABOUT EMERGENCY CONTRACEPTIVE PILLS – TRUE OR FALSE

1. Emergency contraception is a type of birth control that can be used *after* a person has sex.

True. Emergency contraception is a pregnancy prevention method that can be used up to 5 days *after* a person has sex.

2. There are several brands of emergency contraceptive pills on the market.

True. PREVEN® and Plan B® are the two brand-name products of emergency contraceptive pills. It is also possible to use different doses of some regular brands of oral contraceptives. (Another method of emergency contraception is the Copper T 380-A IUD; a device that must be inserted by a medical practitioner. The IUD is seldom used for teens.)

3. ECPs can only be obtained from a doctor.

False. Currently, in the U.S., you need a prescription to obtain ECPs but physicians and other health-care practitioners with the authority to prescribe medication may call in prescriptions to a pharmacy; so an office visit may not be needed. In four states—Washington, California, Alaska, and New Mexico—you can go directly to a participating pharmacist and obtain ECPs there without first contacting a physician. These pharmacists have special arrangements with health-care practitioners to provide this service.

4. Emergency contraceptive pills are 100% effective in preventing pregnancy when taken within 3 days of unprotected sex.

False. Emergency contraceptive pills reduce a woman's risk of pregnancy by 75 to 94 percent when taken within 3 days of unprotected sexual intercourse.

5. Emergency contraception is expensive.

False. Without insurance emergency contraceptive pills cost about $20-25. Some clinics may require teens to have a medical exam, which is an additional expense. Most family planning clinics, however, offer free or low-cost services to teenagers.

6. ECPs can cause any dangerous side effects.

False. While there may be side effects, they are not dangerous. Some women taking ECPs may feel nauseous, dizzy, or tired. Some women vomit and have a headache or sore breasts. These side effects are temporary and should last less than a day or two. There are no medical risks in taking ECPs. In fact, research show that emergency contraceptive pills are safer than aspirin.

7. ECPs cannot cause an abortion.

True. Emergency contraceptive pills work by preventing pregnancy, not by causing abortion.

8. Emergency contraception may be harmful to a developing fetus.

False. There are no know cases where ECPs have caused birth defects or abortion if a woman is already pregnant when she takes them. Over the years, a great number of women who have been pregnant have mistakenly taken birth control pills (containing the same hormones as ECPs) without negative effects to their babies.

9. Emergency contraceptive pills protect against sexually transmitted infections, including HIV.

False. ECPs prevent pregnancy, not STIs or HIV. Using condoms every time a person has intercourse is the best way to prevent STIs and HIV.

10. A teenager has the legal right to obtain emergency contraception without her parent's permission.

True and False. It depend on where the teen receives services and who pays for those services. Most Planned Parenthood and public family planning clinics offer confidential services to teens. Nevertheless, some private physicians' offices and health clinics require parental consent.

11. It is a good idea for young women to have a prescription for emergency contraceptive pills on hand in case they need it.

True. Because the first ECP dose should be taken as soon as possible after unprotected intercourse, medical experts encourage women to obtain and fill a prescription before the need for emergency contraception arises. It is important that women check the expiration date before using the pills to make sure the expiration date has not passed.

EMERGENCY CONTRACEPTION ROLE PLAYS

Purpose: To practice the specific interactions and communication skills needed to discuss emergency contraception. To generate different perspectives on what works/what doesn't work in "real situations."

Materials: Role-play descriptions

Planning notes: Incorporate a role play into a broader lesson on emergency contraception. First have participants learn about EC; you can use our PowerPoint presentation (see Toolbox-3) as well as give out the EC facts sheet (see Toolbox-2).

Procedures

1. Present the objectives and rationale for the role play.

2. Hand out the role-play sheets and briefly describe the situation.

3. Have participants work in groups of two to problem-solve for 5-10 minutes.

4. Once all participants have had a chance to read the description and plan, ask for two volunteers to act out the two characters.

5. Instruct the observers to look for effective verbal and nonverbal communication during the role play.

6. Set the stage and begin the role play. Keep it short (5-7 minutes).

7. If a communication problem arises, "freeze" the role play and have a short discussion on what should happen next. Come to a group consensus as to the next step in the role play and continue the role play.

8. After the role play, go over the questions on the role-play hand out. Here are some general questions:

   (1) What went well during the conversation?
   (2) How did each actor contribute to an effective dialogue?
   (3) What were the challenges that each character faced?
   (4) What cold have been done/stated differently?

9. Ask the "actors" to share how it felt to be in their role. Show appreciation for the role-play volunteers.

ROLE-PLAY #1: FINDING A TRUSTED ADULT

Participant Roles

Frances: Frances, age 16, is dating Jason, and they recently had sex for the first time. Frances insisted on using a condom; Jason was hesitant but agreed. The condom slipped off, but because they did not have a lot of experience, they didn't notice. Frances has plans to go on to college in a couple years and has no intention of having children at this point in her life. She is also really embarrassed to talk to an adult about sex and has no idea that there is any way to try to prevent pregnancy after sex.

Maria: Maria, age 16, is Frances' best friend. Maria has been dating Bill for a few months and is contemplating having sex with him. She's picked up literature at the health clinic about safer sex. She has heard of ECPs but doesn't know that much about them other than you have to take it pretty soon after sex.

Situation: Frances is extremely upset. She doesn't know what to do and is afraid she might be pregnant. Maria spots her in the hall and notices she is upset. When Frances tells Maria what happened, Maria remembers one of the ECP pamphlets she picked up at the clinic. She asks Frances if she's heard of ECP, and Frances says no.

Focus of Role Play

It is Maria's job to convince Frances to go get help quickly. Frances is extremely resistant about talking to an adult because she doesn't want her mom to find out that she had sex.

Audience questions

1. What did Maria say to Frances that motivated Frances to seek help from an adult?
2. What did you notice in Maria's body language that helped convince Frances?
3. How did Maria convince Frances to find out more about ECP?
4. What else could Maria have said or done to convince Frances to seek help?

This role play provides the opportunity to:

- practice peer counseling
- stress importance of responding quickly
- practice motivating someone to get EC by going to the doctor or pharmacist
- explain resources available
- practice ways to offer support—help someone make the phone call; accompany the person; give information and suggest how to get to the clinic or pharmacy; use of self as an example

Note: Frances and Maria can turn into Frank and Marc if male participants are available for role plays. One of the boys is worried about how to help his girlfriend get confidential access to ECPs. The other has heard there is a "morning-after pill" and tries to help.

ROLE-PLAY #2: COMMUNICATING EC INFORMATION TO A PARTNER

Participant Roles

Jimmy: Jimmy, age 17, has been dating Michelle for a few months and they just started having sex. Up until this point, Jimmy hasn't thought about the consequences of having unprotected sex.

Michelle: Michelle has been worried as of late that she and Jimmy have been having unprotected sex. She is afraid of being pregnant but has been afraid to talk to Jimmy about it.

Situation

It's Friday night and Jimmy and Michelle just had unprotected sex and this time Michelle decides to share with Jimmy that she is really worried that she could become pregnant and expresses her concerns about unprotected sex. Michelle and Jimmy begin to talk through their options. Michelle has heard of ECPs from a friend and suggests it as a possible option. Jimmy has never heard of it so Michelle tells him the little bit that she heard from her friend. Jimmy responds to this information and suggests what they can do the next time they have sex so they don't get pregnant.

Discussion points for role players:

- explain EC to a partner
- discuss safer sex
- discuss the urgency of getting EC
- discuss the steps for accessing EC
- demonstrate shared responsibility in a relationship for pregnancy prevention

Audience questions

1. What did Michelle say to Jimmy that was effective in getting Jimmy to understand the importance of protected sex?
2. What did you notice in Michelle's body language that helped convince Jimmy?
3. How did Michelle convince Jimmy that they should use protection?
4. What else could Michelle have said or done to convince Jimmy to have protected sex?

ADDITIONAL EC ROLE PLAYS*

These role play concepts were developed and pilot-tested by the Mailman School of Public Health, Columbia University to increase peer educators' EC knowledge. Chose the ones that best fit your participants' needs and elaborate on them as much as you like.

1. Two girlfriends are talking, and one discloses that she went to a club last night, got drunk and had unprotected sex with a guy who she had just met who told her he loved her. When she woke up he was gone and now she's worried about being pregnant. The friend describes EC and how it can be used.

2. A mother and son are speaking, and the mother warns her son to beware of all the "hotties" out there. She explains that he should wear a condom every time but if it tears or comes off—she explains how EC works.

3. On prom night, a boy and his girlfriend decide to have sex. They do not use a condom. Worried, she goes to the clinic, and the clinician explains how EC works.

4. Four guys are talking together. One discloses that he pretended to have a condom on the night before. Two friends warn him about getting a sexually transmitted infection, and the third explains how ECPs can prevent pregnancy.

5. After having sex, a guy and a girl notice that the condom slipped. The girl tells her partner what she knows about EC and asks her boyfriend to help her get it.

6. Three girls are talking about another one of their friends who recently learned she was pregnant. One of them explains how EC works and tells the others how they can prevent unintended pregnancy.

7. A peer educator is telling a group of students about ECPs and other forms of birth control. One of the students asks whether ECPs cause an abortion. How would the peer educator respond?

*Role plays 1-6 were designed by the Mailman School of Public Health, Columbia University, New York.

SUGGESTIONS FOR INTEGRATING EC INTO ACADEMIC CURRICULA

Students can learn about EC in the context of other academic subjects. This technique has been used effectively in the field of HIV/AIDS prevention. Below are some suggested ways that information about EC can be integrated into academic subjects.

History/Social Studies

- Discuss EC in conjunction with freedom and human rights.
- Ask students to consider EC within the context of the history of the women's movement.
- Conduct research to identify the ways that EC is offered in other countries (e.g., by prescription, on pharmacy shelves without a prescription, and directly from pharmacists without a prescription). Discuss the social and cultural reasons that countries may differ in the ways they make EC available to women.
- Discuss EC as an example of a topic where grassroots political action can make a difference. Research and debate proposed federal or state legislation or regulations such as those determining the kind of sexuality education offered in schools (abstinence and/or comprehensive sexuality education) or mandating EC availability in emergency rooms for victims of sexual assault. Encourage students to write letters to elected officials.

Math

- Take a poll of EC knowledge around the school. You can ask simple questions such as:

  1. Have you ever heard of emergency contraceptive pills, which are also known as morning-after pills?
  2. As far as you know, are emergency contraceptive pills or morning-after pills currently available in the United States?
  3. From what you know, how soon after sexual intercourse do emergency contraceptive pills need to be taken to prevent pregnancy: immediately, within 12 hours, within 24 hours, within 120 hours, within a week, not sure.
  4. Not thinking about yourself in particular, do you approve or disapprove of the use of emergency contraceptive pills to prevent pregnancy for people your age?[1]

- Tally the results and determine the percent of students giving each response. If you ask respondents for their age and gender, see if the answers differ for males and females and for older and younger students.

English/Language Arts

- Show students EC flyers and ask them to write reaction papers.
- Ask students to write persuasive essays supporting or opposing EC.
- Have students write an article about EC for a school or community newspaper.

Art

- Develop posters for an in-school EC ad campaign
- Create collages on teens and EC.
- Create a documentary video about adolescents and emergency contraception.

Biology

- Discuss EC in a class on the female reproductive system.
- Describe how EC and regular oral contraception works.

[1] These questions were taken fully or partially from the telephone survey conducted in 2002 by Princeton Research Associates for the Kaiser Family Foundation and Lifetime Television.

Toolbox 5

Sample Newsletter Articles about EC

Simkin, L, 2001, Preventing Pregnancy After Unprotected Sex—Helping You Answer Your Students' EC Questions, HIV/AIDS Team Newsletter, NYC, unpublished.

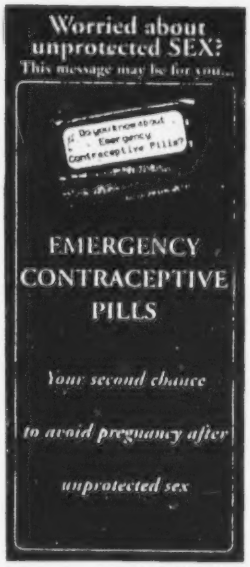
Simkin L, 2001, Preventing Pregnancy AFTER Unprotected Sex. *Joining Hands*, 1:3 and 6.

Note: you can receive electronic copies of these articles by contacting Elayne Archer at earcher@aed.org.

BEST COPY AVAILABLE

PREVENTING PREGNANCY—*AFTER* UNPROTECTED SEX
Helping you answer your students' EC questions

By Linda Simkin, Senior Program Officer; and Stacy Silverstein, Research Associate, Academy of Educational Development



Keeping adolescents safe and healthy today is a challenge. High rates of HIV and unplanned adolescent pregnancy certainly indicate one thing: that young people are having difficulties protecting themselves.

Many do not prepare for sex, especially if they are just becoming sexually active, and some are forced to have sex. Others have problems ob-taining condoms or accessing health care for methods of birth control, and many who try to protect themselves need practice before becoming proficient or consistent users of condoms or other pregnancy prevention methods. For example, condoms can slip or break, and girls may forget to take their pills or get another shot.

SPARK counselors, guidance counselors, school nurses and teachers are often the people that youth trust with questions and concerns about many important aspects of their lives—including unintended pregnancy. That's why you need to know about Emergency Contraceptive Pills (ECP)—a way to prevent unintended pregnancy after sexual activity.

HERE ARE THE FACTS:

Emergency Contraceptive Pills are concentrated doses of ordinary birth control pills that can prevent pregnancy. They require two doses. The first dose should be taken within 72 hours after unprotected sex. The second dose is taken 12 hours later. The FDA has approved two ECP products: PREVEN and Plan B. In addition, the FDA has approved the use of specific doses of 11 types of regular birth control pills for emergency contraception. ECP requires a doctor's prescription.· ECP is safe. ECP has been used by women outside the U.S. for 30 years. Because only a small number of pil ls must be taken over a short period of time, ECP can be used by women who otherwise cannot take birth control pills on a regular basis. Using ECP will not affect a woman's ability to get pregnant in the future. If they are taken by mistake by someone who is already preg-nant, ECP will not harm the developing fetus. ECP is consid-ered so safe that the American College of Obstetricians and Gynecologists and other groups have petitioned the FDA to make ECP available in pharmacies over the counter, as it is in other countries such as England and Belgium.

ECP is effective. Effectiveness in pre-venting pregnancy ranges from 75%-89%, and ECP is more effective the sooner it is taken after unprotected sex. ECP is recommended for emergency use only, because other methods are more effective for preventing pregnancy and it does not protect against HIV/AIDS or other STDs. ECP will not cause an abortion. ECP is not the same as the abortion pill (RU486/Mifepristone) which will end a pregnancy up to seven weeks after the last menstrual period. ECP prevents a pregnancy before an embryo becomes implanted in the uterus—the accepted medical definition of pregnancy.

ECP is inexpensive—it costs between $18 and $35. ECP is covered by Medicaid and some private insurance companies. These prices do not include the cost of a visit to a healthcare provider to obtain the prescription. ECP is avail-able at many health clinics and all Planned Parenthood clinics, with fees often based on ability to pay. ECP use is strictly confidential and parental consent is not necessary to receive a prescription or purchase the pills. Many healthcare providers give women an ECP prescription to have on hand in case of an emergency.

WANT TO KNOW MORE?

Because many healthcare providers and consumers still lack adequate and accurate information about emergency contraceptive pills, the Academy for Educational Development has been working over the last four years to provide free training and adolescent awareness materials to adults (e.g., physicians, pharmacists and educators) who work with adolescents. Our work at the Academy for Educational Develop-ment is supported by private foun-dations. We have trained assistant principals for Health and Physical Edu-cation in two boroughs and our materials have been used in school-based clinics and by Teen Outreach and Pregnancy Prevention staff. Also, we have trained staff from community-based or-ganizations that work in schools (e.g., Teen Choice and Girls, Inc.).

If you are interested in organizing a 30-60 minute ECP training workshop for teachers or support staff in your school, or in obtaining ECP awareness materials (poster, brochures, dj cards, gummed information pads), please contact Stacy Silverstein at 212 367-4565, or email ssilvers@aed.org.

For more information about ECP in general, visit www.not-2-late.com or www.advocatesforyouth.org or www.ppnyc.org or call 1-888-NOT-2-LATE (1 888 668-2528)

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PREVENTING PREGNANCY AFTER UNPROTECTED SEX

By Linda Simkin, Academy for Educational Development

If you serve adolescents in school-based health programs, you have probably counseled the panicked young woman who had unplanned, unprotected sex, the student who was forced or cajoled into having unprotected sex, the couple that experienced condom breakage or slippage, and perhaps the adolescent who had sex despite missing two birth control pills or was late in receiving a contraceptive injection.

Now there is a contraceptive option for avoiding pregnancy after unprotected intercourse – emergency contraceptive pills (ECP). Although they are commonly, but misleadingly, referred to as the "morning after pill," ECPs can be used effectively up to 3 days (72 hours) after unprotected sex and possibly later. ECPs do not cause an abortion since they do not disrupt an established pregnancy.[1] This method of pregnancy prevention has been used safely since the 1960's, primarily in other countries. In 1997, the FDA approved the off-label prescribing of certain combined (estrogen and progestin) oral contraceptive pills for emergency contraception. Subsequently, the FDA approved two dedicated EC products—Preven™ (estrogen/progestin) in 1998 and Plan B™ (progestin-only) in 1999. Nationwide surveys of physicians, pharmacists, and the general public conducted in the last few years have shown that there is either a low level of awareness or high level of confusion about ECPs. And the recent FDA approval of mifepristone, the "abortion pill," has added to the confusion. School-based health care providers have a crucial role to play in educating both colleagues and adolescents about ECPs as a prevention option prior to pregnancy. In addition, SBHC providers are uniquely positioned to increase access to ECP within the narrow 72-hour window.

Emergency contraceptive pills must be prescribed and they require two doses. The first dose should be taken within 72 hours of unprotected sex and the second dose 12 hours later. Progestin-only pills (Plan B) reduce the risk of pregnancy by 89% and combined pills reduced the risk by 75%.[2] According to the World Health Organization, there are no contraindications for ECPs because the hormone dose is small and the duration of use is short. ECPs are even safe for women who cannot use oral contraceptives. In addition, they will not harm a developing fetus if the woman is already pregnant. Studies of oral contraceptives (containing the same ingredients) taken in early pregnancy show no increased risk of problems for mother or baby. ECPs work through one of a combination of possible mechanisms of action: inhibition or delay of ovulation, inhibition of fertilization, or preventing implantation of a fertilized egg through alterations in the endometrium.

These days, we are used to seeing major advertising campaigns for new drugs but this is unlikely to be the case for ECPs. The one-product companies producing ECPs (Women's Capital Corporation and Gynetics) do not have large marketing budgets to spread the word about their products. It is therefore up to providers to inform patients about ECPs whenever birth control is discussed. The key messages to convey to patients include: safety and effectiveness, starting ECPs within 72 hours of unprotected sex, the mechanisms of action, and what to do to reduce possible side effects of nausea and vomiting. In addition, it is critical to tell patients that *ECPs do not protect against STDs and that other forms of contraception are more effective for ongoing birth control.* Adolescents may raise questions about confidentiality, costs, and impact on future pregnancy. Before prescribing ECPs, it is important for school-based health care providers to make sure that pharmacies stock them.

There have been a number of interesting initiatives in the US and other countries to increase access to emergency contraceptive pills. At regular check-ups, many providers give patients prescriptions or cut-up oral contraceptive pill packs with instructions for use so patients will have ECPs when needed, e.g., nights and weekends when clinics are closed. (While there has been some concern about the impact of advance provision of ECPs, a recent study of women ages 16-44 in Scotland found that those who received ECPs in advance of need used them no more often than women in a control group who were only informed about ECP. Moreover, women did not substitute ECP for other forms of contraception.[3]) Some clinics make ECP prescriptions available over the phone using a screening protocol. In Washington State, pharmacists can prescribe ECP directly if they received training and enter into collaborative agreements with a prescriber. In France, where an ECP product, Norlevo, is available over-the-counter, the French Parliament recently approved its distribution by school nurses.

This is an exciting time for providers who seek to help adolescents avoid unplanned pregnancy but many still lack

complete or accurate infofmation. New emergency contraception products and policy initiatives are in the pipeline. To obtain more information, contact the EC website, http://not-2-late.com. The EC hotline (1-888-NOT-2-LATE, 1-888-668-2528) has information in Spanish, French and English as well as a list of ECP providers by area. For information about ordering ECP outreach materials for adolescents, contact AED, 212-243-1110.

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References

1 The National Institutes of Health and the American College of Obstetricians and Gynecologists both define pregnancy as beginning at the completion of implantation.

2 If 100 women have unprotected sex in the 2nd or 3rd week of their cycle, it is expected that 8 would become pregnant. If all 100 used the progestin-only regimen only one would become pregnant, an 89% risk reduction. Similarly, two would be expected to become pregnant if all 100 took the combined regimen, a 75% risk reduction.

3 Glasier A, Baird D. The effects of self-administering emergency contraception. *The New England Journal of Medicine 1998;339:1-4.*

Article reprinted from *Joining Hands*, winter 2001,1:3,6.

Toolbox 6

Resources for School Based Clinics

* EC Survey for School-Based Clinic Health Practitioners
* School-based Clinic Policy and Procedures on EC
* Emergency Contraception Protocol
* EC Patient Informed Consent Form—English and Spanish
* EC Reminder Sheet—English and Spanish
* EC Progress Notes

EMERGENCY CONTRACEPTION SURVEY FOR SCHOOL-BASED CLINIC HEALTH PRACTITIONERS

The questions below concern your experience in your school-based clinic(s) with Emergency Contraceptive Pills (ECP). As you are probably aware, ECP, also called "the morning after pill," can be used to prevent pregnancy after sex and, unlike RU-486, ECP cannot disrupt an existing pregnancy. Please complete a separate survey for each of your high school clinics.

1. In the high school you serve, approximately how many students are aware of ECP?
   ___0-25% ___26-50% ___51-75% ___75-100%

2. In the past 3 months, how many students have asked providers in your clinic about ECP?
   ___0 ___1-10 ___11-20 ___21-30 ___more than 30

3. How often are adolescents, who have been sexually active, informed by clinic staff about ECPs?
   ___Never ___Sometimes ___Often ___Always

4. How often are adolescents, who never have been sexually active, informed by clinic staff about ECPs?
   ___Never ___Sometimes ___Often ___Always

5. How is ECP handled in your clinic? *(Check all that apply.)*
   ___We dispense ECP at the school-based clinic.
   ___We write prescriptions for ECP at the school-based clinic.
   ___We refer students to another clinic.
   ___We do not dispense, prescribe, or make referrals for ECP.

6. In the past 3 months, how many times did your clinic *dispense or prescribe* ECP?
   ___0 ___6-10 times ___16-20 times
   ___1-5 times ___11-15 times ___more than 21 times

7. Does your school-based clinic have written protocols or policies about prescribing ECP?
   ___Yes ___No

8. In general, would you say that your experience with ECP and adolescents has been:
   ___positive ___negative ___not enough experience to say

9. What, if any, concerns do you have about ECP? *(Use back of survey if you need more space)*

10. Have you ever received any formal training about ECP? ___Yes ___No

11. Are there any materials about ECP in your school-based clinic? ___Yes ___No

12. **Would you like to receive, free of charge:** *(Check all that apply.)*
    ___training about ECP for school-based clinic practitioners
    ___written information about ECP for adolescent health care providers
    ___web-based resources about ECP
    ___EC outreach materials designed for teens (e.g., posters, brochures, wallet and DJ cards)
    ___other (Please explain.)

Thank you for your help!

SAMPLE SCHOOL-BASED CLINIC POLICY AND PROCEDURES ON EC

Title: **Emergency Contraception**

Date Issued:

Issued By:

PURPOSE: To assure that students who meet the criteria for emergency contraception are offered this service, and that staff comply with all requirements for providing emergency contraception.

POLICY: All students who report having unprotected sexual intercourse will be screened to determine if they meet the criteria for emergency contraception. For students who meet the criteria, this service will be offered either directly at the school for high school students, or through a referral to the back-up clinic for the intermediate schools unless there is specific parental consent for this service. Parental/guardian involvement must always be explored and encouraged.

PROCEDURE: All students who meet the criteria for emergency contraception – unprotected sexual intercourse in the past 120 hours (5 days) – will be provided with information about emergency contraception. All students who are sexually active should be routinely asked when they last had intercourse and if it was unprotected.

A. On Site Dispensing of Contraceptives

For sites with on-site dispensing of contraceptives, the same procedure applies as at the back-up clinic. See *Protocol for Emergency Hormonal Contraception* attached.

B. Sites Without On-Site Dispensing of Contraceptives

1. Students reporting unprotected sexual intercourse in the past 120 hours must be seen by a health educator and a medical provider. If a student is interested in this option, timeliness is imperative. (If the health educator is not available, refer to the mental health worker).

2. If the medical provider and the health educator feel that the student is a good candidate for this service, in most cases it will be handled as a contraceptive referral. (See Referral of Sexually Active Students to the Back-up Clinic).

3. Parental involvement must be explored and encouraged whenever appropriate. **If parental consent for on-site contraception is obtained, emergency contraception can be provided at the school-based clinic site.** The consent for on-site contraception should be filled out. If time does not allow for this, verbal telephone consent is acceptable. This verbal consent (date, time, name, and relationship of parent/guardian, etc. should be documented on the consent form).

4. Students will receive counseling and medical clearance, including pregnancy testing, at the school. Particular attention should be paid to the students' understanding of the possibility of severe nausea and an assessment of their ability to deal with this reaction on their own.

5. All students will receive informed consent, including fact sheets, and must sign consent forms for emergency contraception and optimally a contraceptive method as well.

   The following **forms** must be used at the school-based clinic:
   - emergency contraception consent form
   - emergency contraception fact sheet (reminder sheet)
   - medical provider emergency contraception form
   - other contraceptive medical, counseling and consent forms
   - on-site contraception consent form, if parental consent is obtained.

6. In cases when the student is referred to the back-up clinic, whenever possible, social workers/health educators will meet the student at the clinic. When this is not logistically possible, paperwork can be faxed to the clinic. Please call the FPC/SBC liaison when you know a student will be going to the clinic. The walk-in provider will see the student.

7. The health educators, social workers, and medical providers should always try to make the emergency contraception visit a much-needed opportunity to start on a **contraceptive method. Quick Start** can be initiated within 24 hours of the last Emergency Contraception dose, either at the back-up or at the SBC when there is parental consent. (See Quick Start P&P, Protocol for Quick Start in SBC Medical Manual, and P&P for On-site Contraception with Parental Consent.) Students going to the back-up for emergency contraception who want to initiate a contraceptive method can be "Quick Started" on oral contraceptives. They should receive three packs of pills. If students receive emergency contraception and are "Quick Started" with parental consent on-site, they should only receive one pack of pills. Students who would like Depo should be "Quick Started" first and given Depo 21 days later following the negative pregnancy test.

8. Students receiving emergency contraception either at the back-up clinic or the SBC should be seen **within 1-2 days at the school-based clinic** to assess their reaction to the process. **If contraception was not initiated, "Quick Start" should be offered at this visit. A three-week follow-up visit should be scheduled. At this three-week appointment, a repeat pregnancy test must be performed.**

9. Mental Health involvement should be considered on a case by case basis.

ATTACHMENTS:

1. Protocol for Emergency Hormonal Contraception (including attachments)

EMERGENCY CONTRACEPTION PROTOCOL

1. OVERVIEW

Emergency Contraception is an important option for pregnancy prevention when a woman or adolescent female has an episode of unprotected sexual intercourse due to not using contraception, episodic contraceptive failure or sexual assault. It has been found to be effective in these circumstances if used within 120 hours of an episode of unprotected intercourse, reducing the risk of pregnancy by approximately 75%. Specified short-term high doses of oral contraceptives containing ethinyl estradial and norgestrel or levonorgestrel work by temporarily disrupting ovarian hormone production and causing an absent or dysfunctional luteal phase hormone pattern or delaying ovulation. An inadequate or absent luteal phase results in out-of-phase endometrial development, making the uterine lining unsuitable for implantation. The hormonal disruption may also interfere with fertilization and cause disordered tubal transport.

2. PATIENT SELECTION

Emergency contraception may be provided at the patient's request, following either the patient's or the provider's initiation, at the Family Planning Clinic:

1. As an emergency measure only – not on a regular monthly basis.
2. Within **120** hours of an episode of unprotected vaginal sexual intercourse (If the patient has had other episodes of unprotected sexual intercourse prior to **120** hours [5 days], this is **not** a contraindication to emergency contraception.
3. While the risk of pregnancy is greatest with mid-cycle exposure, emergency contraception may be offered for unprotected sexual intercourse at any time during the cycle.

   Patients calling for emergency contraception will be asked when their last unprotected sexual intercourse was. If it was within the last **120** hours, the patient will be instructed to come to the clinic ASAP. An appointment slip will be made out, indicating emergency contraception, and will be brought immediately to the front area to have the chart pulled and staff alert to have the patient seen immediately. Patients who have been to the clinic before will be seen by their regular provider whenever possible. If the patient will be unable to arrive before the clinic closes on Thursday, she will be referred to another site that offers emergency contraception.

   Patients must receive a copy of the emergency contraception reminder sheet and must sign the Emergency Contraception form prior to the provision of emergency contraception.

3. CONTRAINDICATION

a. **Absolute contraindication** – Emergency contraception is contraindicated if there is evidence or suspicion of an established pregnancy.

b. **Relative contraindications** – While the contraindications listed below are absolute with oral contraceptives, they are relative with emergency contraception due to the relatively low dose of contraindication, consultation with the Medical Director is required to assess if the potential benefits of the drug outweigh the potential risks.

- Thrombophlebitis or emboli
- Uncontrolled hypertension

4. EVALUATION BEFORE INITIATION

All clinical information will be documented on the emergency contraception clinic form. Prior to the provision of emergency contraception, the following must be done:

1. History, as indicated on the emergency contraception clinic form. **If this is the patient's first visit to the clinic, initial interview with counseling is required as with any new patient.** (For these patients, the new patient physical exam can be deferred until the next follow-up visit.)
2. Explore patient's feelings regarding continuing the pregnancy if the treatment fails. Although there is no evidence that emergency contraception would be harmful, it cannot be guaranteed that there will be no effect on the fetus.
3. Discuss options with the patient, including use, side effects, possible risks, failure rates, necessary follow-up, warning signs of possible complication. Help the patient decide if she wants to be treated, informing her of option to "wait and see" – if no menses, a pregnancy test will be performed at her three week follow-up visit. (Patients who choose to wait and see can be offered "Quick start" to initiate contraception – see procedure, p. 47 of manual.)
4. Highly sensitive urine pregnancy test
5. Blood pressure
6. Additional exam or lab tests as per provider's judgement, based on criteria for any routine contraceptive visit.

Patients who have not had a physical exam within one year will have this at the required three week follow-up visit.

5. MANAGEMENT

a. Medication

The only hormones that have been studied in clinical trials of ECPs are the estrogen ethinyl estradiol and the progestin levonorgestrel or norgestrel, (which contains two isomers, only one of which – levonorgestrel – is bioactive). The current treatment schedule is one dose within 120 hours after unprotected intercourse, and a second dose 12 hours after the first dose. The following medications can be prescribed in the indicated doses:

Medication	Dose		Dispense
Plan B	1 tablet	repeat in 12 hours	2 tablets
Preven	2 tablets	"	4 tablets
Alesse	5 tablets	"	10 tablets
Lo-Ovral	4 tablets	"	8 tablets
Nordette	4 tablets	"	8 tablets
Levlen	4 tablets	"	8 tablets
Tri-Levlen (yellow)	4 tablets	"	8 tablets
Triphasil (yellow)	4 tablets	"	8 tablets
Ovral	2 tablets	"	4 tablets

The patient must be instructed to call if vomiting occurs within 30 minutes of taking the first dose to get an additional dose.

The medication provided in pre-packaged envelopes with information completed on the date, patient's name and address, medical record #, medication #, tablet, expiration date, lot #, and instructions for use. The specific time(s) to take the medication must be indicated. Whenever feasible, the patient should take the first dose at the clinic while she is with the provider.

Plan B emergency contraceptive pills have a very low incidence of nausea and vomiting, obviating the need for anti-nausea medications. If nausea treatment is necessary, the following regimens may be prescribed. To treat nausea, Tigan 200 mg. rectal suppositories #2, one taken one hour prior to one or both emergency contraception doses, may be dispensed for clinic or home use (warn patients not to drive or use dangerous equipment). Nonprescription alternatives to this are dimenhydrinate (Dramamine) 50 mg., 1-2 tablets p.o. q 4-6 hours, or cyclizine hydrochloride (Marezine) 50 mg., one tablet p.o. q 4-6 hours. Ginger tablets and peppermint tea can also be offered as alternatives for treating nausea and vomiting.

b. Side Effects

Patients will be informed that nausea and vomiting are common during treatment, and that some women experience breast tenderness, abdominal pain, headache or dizziness. Side effects subside within 1-2 days following treatment. Emergency contraception will almost certainly alter the timing of the next menstrual cycle. About 90% of patients will bleed within three weeks.

c. Contraception

Patients will be counseled on available contraceptive methods, and contraception will be initiated whenever possible or patient will be given an appointment to obtain her method of choice. Patients on oral contraceptives who want to continue them will be instructed to throw away the current pack and start a new pack of pills on the following Sunday (as in OC procedure when patient misses 3 or more pills). They must use a barrier method for at least seven (7) days after starting the new pack.

Patients who want to **initiate** oral contraceptives, Depo-Provera, Norplant or the IUD can be handled as with "quick start," procedure (see Section IIIC). Again, a barrier method must be used for at least 7 days. At a minimum, condoms and foam will be provided.

d. Sexually Transmitted Infections

Patients will be provided with information on sexually transmitted infections, including safer sex practices. New patients or patients not seen for over three months will be provided with HIV counseling and offered HIV testing.

e. Sexual Assault

Patients stating that they have been sexually assaulted must be referred to a social worker and will be counseled according to clinic counseling protocol. Extraordinary efforts should be made to get the patient to the emergency room. If patient refuses to go to the ER, the provider should consult with the Medical Director or her designee who will make the final decision as to whether the patient should be examined at the Family Planning Clinic. (See also Sexual Assault protocol.)

f. Complications

Patients must be instructed to return to the clinic immediately or go to the nearest emergency room if they develop severe chest or arm pain, shortness of breath, unusual leg pain or swelling, severe headache, blurred or double vision, severe abdominal pain, heavy vaginal bleeding, jaundice or severe depression.

6. FOLLOW-UP

Patients receiving emergency contraception will be informed that their next menstrual cycle will probably be different than usual. Patients should return to the clinic in three or four weeks if no menses for a urine pregnancy test. If the test is negative, the patient can either continue with oral contraceptives or switch at the time to any other method of choice. New patients may be given up to three months or oral contraceptives and instructed to return to clinic within three months for a comprehensive examination if indicated. Adolescents should be encouraged to return to the clinic as soon as possible in order to more carefully monitor compliance. They must then return at the required time depending on the specific method they are using (see specific sections on methods).

If the patient has not had her normal menstrual period at the time of the follow-up appointment, or pregnancy is suspected for any reason, a highly sensitive pregnancy test, and pelvic exam must be performed. If the patient is pregnant, she will be referred to the social worker for counseling and follow-up as per clinic procedure for early pregnancy diagnosis.

It is our intention that all patients receive an advance prescription for ECPs so that in the event that they need it, they will not have to come to the clinic for a visit. In order to achieve this, all new and annual patients will be given undated prescriptions for ECPs. In addition, patients will receive a fact sheet on ECPs, as well as information on the necessity for follow-up. Given the fact that all ECP medication may not be available at all pharmacies, prescriptions should be written as follows:

RX
Disp. Plan B
if unavailable PREVEN
if unavailable LO OVRAL
Sig: As directed
REFILL x 3

New York Presbyterian Hospital
New York, NY 10032-3784

CONTINUATION SHEET

MRN:

NAME:

D.O.B. SEX:

EMERGENCY CONTRACEPTION CONSENT FORM

I agree that I am receiving Emergency Contraception Pills (ECP) of my own free will. I request ECP because I do not wish to be pregnant and have had unprotected vaginal intercourse within the past 120 hours (5 days).

I understand that the ECP method has the same hormones, though in different amounts, that are used in birth control pills. These pills are taken after having unprotected vaginal intercourse to prevent pregnancy. The are to be used as an emergency measure only and not as a routine method of birth control.

It has been explained to me that ECP works by either keeping the ovary from releasing an egg or changing the lining of the uterus (womb) so that the fertilized egg cannot attach and develop into a pregnancy.

I understand that ECP lowers the risk of pregnancy by 75% so that it is possible for me to become pregnant even if I take this medication. If a failure occurs, the risks to a fetus may be small, but are unknown. I understand that abortion remains an option if I become pregnant.

I know that a sensitive urine pregnancy test must be done to try to rule out an already existing pregnancy.

I am aware that some reactions to ECP may include:

Nausea and/or vomiting **Irregular vaginal bleeding**
Breast tenderness **Headache**

I understand that I need to seek immediate health care if I have severe new pain in any part of my body, particularly severe headaches or severe pain in my abdomen, chest or legs.

I understand that if I see a health care provider for any reason before I get my period, I should tell her/him that I have taken ECP.

I understand that ECP does not protect me from STDs and HIV. It is best to use a condom to reduce my risk for STDs and HIV.

A fact sheet on the use of ECP has been give to me. No guarantee or assurance has been made to me as to the results of using this method. I understand that neither the provider nor the hospital are in any way responsible should I become pregnant.

I have been given a chance to ask questions about ECP and all of my questions have been answered to my satisfaction.

I know that I must return to this clinic in four (4) weeks if I do not get my period. If I get my period, I am to return at my next scheduled appointment.

Signature of Patient: _____ Date:_____

Signature of Witness:_____ Date:_____

Revised 5/02

New York Presbyterian Hospital
New York, NY 10032-3784

CONTINUATION SHEET

MRN:

NAME:

D.O.B. SEX:

CONSENTIMIENTO PARA RECIBIR ANTICONCEPTIVOS DE EMERGENCIA

Dejo constancia de que estoy recibiendo las Píldoras Anticonceptivas de Emergencia (ECP, por sus siglas en inglés) por mi propira voluntad. He solicitado las ECP porque no deseo caer encinta y he tenido relaciones sexuales sin estar protegida, en las últimas 120 horas, (cinco dias).

Tengo entendido de que el método ECP tiene la mismas hormonas, aunque en cantidades distintas, que se usan en las píldoras para el control de la natalidad. Estas píldoras se toman después de haber tenido relaciones sexuales sin protección, para evitar el embarazo. Deben usarse únicamente como medidas de emergencia y no son un método retinario para controlar la natalidad.

Se me ha explicado que las ECP funcionan ya sea evitando que el ovaria desprenda un óvulo fertilizado no se le peque y termine en un embarazo.

Tengo conocimiento de que algunas reacciones de las ECP pueden incluir:

Náuease y/o vómitos
Sensibilidad en los senos
Pérdida irregular de sangre vaginal
Dolor de cabeza

Comprendo que necesito recurrir inmediatamente a un proveedor de salud si siento nuevos dolores agudos en cualquier parte de mi curepo, especialmente dolores fuertes de cabeza o dolores fuertes en mi amdomen, pecho o piernas.

Tengo entendido de que si por cualquier razón acudo a un proveedor de salud antes de tener mi período, debo decirle que he tomado ECP.

Tengo entendido que el uso de ECP no protejé contra el VIH y/o enfermedades sexuales.
Es mejor utilizar condones para protejerme contra el VIH y/o enfermedades sexuales.

Se me ha dado una hoja de datos sobre el uso de ECP. No se me ha dado ninguna garantía o seguridad sobre los resultados del uso de este método. Comprendo que ni el proveedor ni el hospital son responsables de modo alguno en caso de que quede encinta.

Se me ha dado la oportunidad de hacer preguntas sobre las ECP y he recibido respuestas satisfactoria a todas mis preguntas.

Se que debo regresar a esta clínica para un examen médico en cuarto (4) semanas si no me ha bajado el período; si el período me baja, tengo que regresar a la próxima cita ya fijada.

Firma de Paciente:_____ Fecha_____

Firma Del Testigo:_____ Fecha_____

120

THE EMERGENCY CONTRACEPTIVE PILL REMINDER SHEET

Your counselor and provider will explain this method to you fully. This sheet is just a reminder.

WHAT IS IT?

Emergency Contraceptive Pills ("the morning after the pill" or "ECP") are a series of pills to use in an emergency. "Emergency" in this case means just one thing — you've had unprotected vaginal intercourse within the past 120 hours, (5 days). If that's your situation you have the option of using them to stop a possible pregnancy before it gets started. After having sex it takes about 5-10 days for a pregnancy to begin. Taking the ECP as soon as possible after unprotected sex usually stops a pregnancy from beginning.

HOW EFFECTIVE IS IT?

Emergency contraceptive pills are very effective — they lower the chance of getting pregnant by 75% or more. The sooner you take ECP, the better it works. If a pregnancy is already established, then ECP won't work.

HOW DO I TAKE EMERGENCY CONTRACEPTIVE PILLS?

- You must take the first does as soon as possible (not later than 120 hours or 5 days) after you've had unprotected sex.
- Take the second dose 12 house after the first dose. If you are given:

PLAN B - Take one pill right away; take on pill 12 hours later.
PREVEN - Take two pills right away; take two pills 12 hours later.
LO-OVRAL - Take four white pills right away; take 4 white pills 12 hours later.

WHAT MIGHT I EXPECT WHEN I TAKE THE PILLS?

- Nausea or vomiting may last one or two days. Eating a snack, drinking a glass of milk or taking ginger tablets or peppermint tea may also reduce nausea.
- Other symptoms like headaches, sore breasts or irregular bleeding.
- Expect to get your period in two or three weeks, come to the clinic for a check-up and pregnancy test.

The above effects are not dangerous and usually go away after about one or two days. You must take both doses of the pills for them to be effective! Talk with your doctor, nurse practitioner, or counselor if you are concerned (342-3232).

ECP does not protect you against STDs and HIV.

PROTECT YOURSELF AGAINST HIV/AIDS AND OTHER SEXUALLY TRANSMITTED INFECTIONS AS WELL AS PREGNANCY. USE CONDOMS EVERY TIME YOU HAVE SEX

ACNC FAMILY PLANNING CLINIC
21 Audubon Avenue
New York, NY 10032
(212) 342-3232

Center for Community Health and Education, Mailman School of Public Health, Columbia University

LA PILDORA ANTICONCEPTIVA DE EMERGENCIA HOJA RECORDATORIA

Su consejero(a) proveedor(a) explicarán este método detalladamente.

¿Que Es?

Las Píldoras Anticonceptivas de Emergencia ("la pildora para la mañana siguiente ó "ECP") son una seríe de píldoras que se usan en caso de emergencia. "Emergencia" en este caso significa una sola cosa: - usted ha tenido relaciones sexuales en las ultimas 120 horas, (cinco dias) sin estar protejida. Si esta es su situacion usted tiene la opción de usarlas para detener un posible embarazo antes que este se inicie. Después de tener relaciones sexuales se toma de 5-10 días para que el embarazo comienze. Usualmente, se puede evitar un embarazo al tomar ECP lo más pronto posible después de tener relaciones sexuales sin protección.

¿Cuán Efectiva es?

Las píldoras anticonceptiva de emergencia son muy efectivas: reducen la posibilidad de quedar embarazada en un 75%. Mientras más rápido lo tome, mejor funcionará. Si hay un embarazo ya establecido, entonces ECP no funcionará.

¿Cómo tomo las píldoras anticonceptivas de emergencia?

- Debe tomar la primera dosis de píldoras lo antes posible (dentro de un máximo de 120 horas o cinco días) después de haber tenido relaciones sexuales sin protección.
- Tome la segunda dosis de píldoras 12 horas después de la primera dosis. Si le dan:

PLAN B - Tome una píldora enseguida; tome la otra píldora 12 horas más tarde.
PREVEN - Tome una píldora enseguida; tome las otras dos píldoras 12 horas más tarde.
LO-OVRAL - Tome las cuatro píldoras blancas enseguida; tome las cuatro píldoras blancas 12 horas más tarde.

¿Que efectos pueden tener las píldoras en mi organismo?

- Náusea ó vómitos: pueden durar uno ó dos días. Otra manera de aliviar las náuseas es comer algo liger, beber un vaso de leche ó tomar tabletas de gengibre ó té de menta.
- Otros síntomas como dolores de cabeza, senos adoloridos ó pérdida de sangre vaginal.
- Calcule que le llegará el periodo en dos o tres semanas. Es probable que empiece unos días antes de lo usual.
- Si en 4 semanas no le ha llegado el periodo, vaya a la clínica para un chequeo y una prueba de embarazo.

Los efectos mencionado no son peligroso y usualmente desaparecen al cabo de uno ó dos días. Para que las píldoras sean efectivas, debe tomas ambas dosis. Si tiene cualquier preocupación, hable con su médico, enfermera (o) ó professional (342-3232).

***PROTEGASE CONTRA EL VIH/SIDA Y OTRAS INFECCIONES DE TRASMISION SEXUAL ASI COMO DEL EMBARAZO — USE CONDONES CADA VEZ QUE TENGA RELACIONES SEXUALES ***

ACNC FAMILY PLANNING CLINIC
21 Audubon Avenue
New York, NY 10032
(212) 342-3232

Patient's Name (Print)

Name: Unit no.:

Phone: Physician:

EMERGENCY CONTRACEPTIVE PILLS
Progress Note

Date: ___/___/___

D: Patient is here for emergency contraception

Last unprotected sex (or broken condom): ___/___/___ = ___ hours ago

When was the patient's Last Menstrual Period (first day): ___/___/___

Was this a normal period? ___ Yes ___ No (if no, please describe):

If LMP>28 days ago, please do UCG: _____ (UCG result).

If LMP<= 28 days, do not do UCG).

What does the patient want to use to prevent pregnancy in the future?

Any other complaints: _____

Optional Questions/nurse's discretion)

Was your sexual encounter with sex/(was sex consensual?) _____

A: Contraceptive Management

P: IF Unprotected sex was within 72 hours of this visit
LMP was within 28 day of this visit
LMP was normal

PATIENT IS APPROPRIATE FOR **PLAN B**:

IF Unprotected sex was within 72-120 hours of this visit AND/OR
LMP was > 28 days ago OR was short but ICON is NEGATIVE

PROVIDER SHOULD BE CONSULTED TO CONFIRM THAT PATIENT IS APPROPRIATE FOR **PLAN B**.

Patient to Health Education for contraceptive counseling. _____.

Patient to schedule GYN _____ P31 _____ Other _____

PLAN B: 1 tablet now PO, 1 tablet in 12 hours, Pt. To RTC 2-3 weeks for repeat ICON if she does not get menses.

_____RN_____NP/MD

The Mount Sinai Medical Center
One Gustave L. Levy Place
New York, NY 10029-6574

Toolbox 7 Management Information and Evaluation Tools

* Emergency Contraception Training Participant List
* ECP Training Evaluation Form
* School/CBO Contact Database
* Materials Database
* EC Training Follow-up Telephone Interview: School Personnel
* EC Training Follow-up Telephone Interview: CBO Staff

EMERGENCY CONTRACEPTION TRAINING PARTICIPANT LIST

Name of Group:_____ Date: _____

Name	Title	School/CBO	Phone	E-mail

TRAINING EVALUATION FORM

Training:_____ Date:_____

1. Are you female or male?
   ① female
   ② male

2. What is your job title?
   _____

3. How often do you talk to teens about birth control as part of your job?
   ① several times a day
   ② several times a week
   ③ several times a month
   ④ several times a year
   ⑤ never

4. How comfortable do you feel discussing birth control with teens?
   ① very comfortable
   ② somewhat comfortable
   ③ neither comfortable or uncomfortable
   ④ somewhat uncomfortable
   ⑤ very uncomfortable
   ⑥ not applicable

5. Prior to today's training, how much did you know about emergency contraceptive pills (ECPs)?
   ① I had never heard of ECPs.
   ② I had heard of ECPs but didn't really know the facts.
   ③ I was somewhat informed about ECPs.
   ④ I knew a lot about ECPs.

6. After today's training, how informed do you feel about ECPs?
   ① very informed
   ② somewhat informed
   ③ very uninformed

7. After today's training, how comfortable will you feel discussing ECPs with teens?
   ① very comfortable
   ② somewhat comfortable
   ③ neither comfortable or uncomfortable
   ④ somewhat uncomfortable
   ⑤ very uncomfortable
   ⑥ not applicable

8. Please rate the following aspects of the training on a scale from 1 (lowest rating) to 5 (highest rating).

	low				high
a. relevance to your job	①	②	③	④	⑤
b. quality of the presentation	①	②	③	④	⑤
c. knowledge of the presenter	①	②	③	④	⑤
d. quality of the handouts	①	②	③	④	⑤

9. To what extent do you agree or disagree with the following statements?

	Strongly disagree				Strongly agree
a. All sexually active teens should be given information about ECPs.	①	②	③	④	⑤
b. Teens should know about ECPs before they become sexually active.	①	②	③	④	⑤
c. Increased availability of ECPs will decrease condom use.	①	②	③	④	⑤
d. Teens who know about EC will not use regular, ongoing birth control.	①	②	③	④	⑤
e. Teenage males should know about ECPs.	①	②	③	④	⑤
f. Practitioners should limit the number of times they prescribe ECPs for a teen.	①	②	③	④	⑤
g. I feel uncomfortable talking about ECPs because of religious or moral beliefs.	①	②	③	④	⑤
h. Teens who have been sexually assaulted should be offered ECPs in emergency rooms, no matter what the religious affiliation of the hospital.	①	②	③	④	⑤

10. Please provide names of other specific groups, working with teens, who ought to receive EC training.

11. Are there any recommendations you can offer to help us improve this training?

Thank you!!

SCHOOL/CBO CONTACT DATABASE

School/CBO Name	Person Contacted	Title	Phone	E-mail	Conducted Training	Gave Materials	Gave TA

MATERIALS DATABASE FORM

CBO/ School	Date	Recipient Contact Information	Posters	Pamphlets (English)	Pamphlets (Spanish)	DJ Cards	Pads

EC TRAINING FOLLOW-UP TELEPHONE INTERVIEW
SCHOOL PERSONNEL

Name: _____ Gender: ___Male ___Female

High School: _____ Phone_____ Date Trained:_____

Title: _____

Interviewer:_____ Date:_____

"Hello. My name is_____ and I'm calling from the _____name of organization_____. You may remember that we did a training on Emergency Contraception (which is also called the morning after pill) in [date]_____. As a follow up to that training, I would like to ask you a few questions that will take about 10-15 minutes. Is this a good time to talk?" [If not, schedule another conversation.]

The purpose of this survey is to assess the emergency contraception training in light of your experience in your school.

---

1. After the EC training did you inform any other adults about EC? ___Yes ___No

   If Yes, who were they?
   ___a. co-worker (circle all that apply: teacher, guidance, administration, other staff)
   ___b. friend
   ___c. relative
   ___d. other

2. Do you supervise adults who educate students about contraception? ___Yes ___No

3. **If Yes,** have you talked to these adults about emergency contraception? ___Yes ___No

   a. If Yes, what was your experience like?_____
   b. If No, why not? _____

4. How comfortable do you feel about discussing EC with adults in your school?
   ___a. Very comfortable ___c. Slightly uncomfortable
   ___b. Slightly comfortable ___d. Very uncomfortable

   [If respondent is uncomfortable, i.e., c or d] What makes you uncomfortable?

5. *Before the training,* had you given any students information about EC?
   ___Yes ___No

6. *Since the training*, have you given any EC information to students in this school?

___Yes ___No

If Yes, what were the circumstances?

7. How comfortable do you feel about discussing EC with students in your school?

___a. Very comfortable ___c. Slightly uncomfortable

___b. Slightly comfortable ___d. Very uncomfortable

8. You may recall that, at the training, we gave out or mailed EC materials that were red and black with a beeper on them. We would like to know if you were able to use any of these materials.

a. In general, have the materials been displayed in the school?

If Yes, where? (e.g. health suite, guidance, classroom, bulletin board)_____

If No, why not? (Probe about barriers—structural or personal)_____

b. **If Yes,** More specifically, we'd like to get a sense of which materials have worked best in your school and why.

Check all that apply:

___a. Have the posters been displayed anywhere in the school? ___Yes ___No

If Yes, where?_____

If No, why not?_____

___b. Are the brochures available to adults or students in the school? ___Yes ___No

If Yes, where? (e.g.; other professionals, parents, and youth)?_____

If No, why not?_____

___ c. Are the DJ cards available (5"x7")? ___Yes ___No

If Yes, to whom?_____

If No, why not?_____

___ d. Did you use the tear-off pads? ___Yes ___No

If Yes, where? (e.g. put on bulletin board)_____

If No, why not?_____

9. Do you need any additional materials? ___Yes ___No

[**If yes,** arrange to send, fax, or e-mail an order form.]

10. Thinking back to the EC training, what was the most important thing you learned?

11. Is there anything else you would like to add with regard to your opinions or experience with EC?

EC TRAINING FOLLOW-UP TELEPHONE INTERVIEW
COMMUNITY-BASED ORGANIZATION STAFF

Name:_____ Gender:___Male ___Female

Organization: _____ Phone:_____ Date Trained:_____

Title: _____Role in the organization:_____

Interviewer:_____ Date:_____

"Hello. My name is_____ and I'm calling from___name of organization_____. You may remember that we did a training on Emergency Contraception (which is also called the morning after pill) as part of a training for _____(name of group). As a follow up to that training, I would like to ask you a few questions that will take about 10-15 minutes. Is this a good time to talk?" [If not, schedule another conversation.]

The purpose of this survey is to assess the emergency contraception training in light of your experience in the field.

---

1. How often do you personally educate or counsel adolescents about contraception?
   _____Several times a day
   _____Several times a week
   _____Several times a month
   _____Several times a year
   _____Never

2. What are your feelings about the importance of providing emergency contraception information to adolescents in your work setting and why?

3. Have you talked to any adolescents about emergency contraception in the past 3 months?

   ___Yes ___No

   a. If Yes, do you know if any adolescent used EC after talking to you about it?
      ___Yes ___No ___Don't Know
   b. If Yes, what was their experience with it (e.g. making an appointment, getting a Rx, taking the pills)?

4. Did you or any of your clients contact:

Self	Client	
___	___	a. the EC hotline number: 888-not-2-late
___	___	b. the not-2-late website
___	___	c. any of the health clinics listed on the materials (specify)_____
___	___	d. other (specify) _____

If Yes: Did you or your clients get the information needed? ___Yes ___No

5. How comfortable do you feel discussing EC with adolescents?

___a. Very comfortable ___c. Slightly uncomfortable

___b. Slightly comfortable ___d. Very uncomfortable

[If respondent is uncomfortable, i.e., c or d] What makes you uncomfortable?

6. Thinking back to the emergency contraception training, what was the most important thing you learned about EC?

7. After the EC training at _____, did you inform any other adults about EC? ___Yes ___No

If Yes, who were they?

___a. co-worker

___b. friend

___c. relative

___d. other

8. You may recall that, at the training, we gave out or mailed EC materials that were red and black with a beeper on them. We would like to know if you were able to use any of these materials.

Check all that apply:

___a. Did you put up the poster?

If Yes, where?_____

If No, why not?_____

___b. Did you give out brochures?

If Yes, to whom (e.g.; other professionals, parents, and youth)?_____

If No, why not?_____

___c. Did you give out DJ cards (5" x 7")?

If Yes, to whom?_____

If No, why not?_____

___d. Did you use the gummed pads?

If Yes, how did you use them? (e.g. put on bulletin board)_____

If No, why not?_____

9. Do you need any additional materials? ___Yes ___No
[**If yes,** arrange to send, fax, or e-mail an order form.]

10.Do you work in any schools?

a. If Yes, name of school(s)/borough_____

b. Have you given any EC information to students in this school? ___Yes ___No

If Yes, what was your experience?

c. Have you given any EC information to adults in this school? ___Yes ___No

If Yes, who were they (e.g. guidance counselor, nurse)? _____

11. Is there anything else that we could have provided you with at the training to help you increase EC awareness and access?

12. Is there anything else you would like to add with regard to your opinions or experience with EC?

Toolbox 8

The New York Story

A Case Study of *You Can't Teach What You Don't Know*

AED's Project to Increase EC Awareness
in New York City Public High Schools and CBOs

THE NEW YORK STORY

The following is a case study of "You Can't Teach What You Don't Know," AED's project to increase awareness about emergency contraception in public high schools and community-based organizations in New York City. It also describes our development of adolescent-friendly emergency contraception materials.

1. INCREASING EMERGENCY CONTRACEPTION AWARENESS IN THE SCHOOLS

LESSONS LEARNED ABOUT EC AND SCHOOLS

* Even in a large, complex, and highly political school system, it is possible to build EC awareness among the many staff who consider this topic very relevant to their jobs.
* School system administrators may be supportive of building EC awareness in their school, but they are concerned that resounding support might create controversy, ultimately derailing this and other prevention efforts. Tacit approval may be all that is needed to begin outreach activities in the schools, with the assistance of allies within the system.
* Since most school staff still lack basic information about EC, training sessions should cover the basic EC facts, as well as school policies and procedures (e.g., materials review, referral, and confidentiality). It is also important to address the appropriate role of educators in providing students with complete, accurate, and nonbiased information so that they can make informed decisions.
* CBOs that partner with schools can be a great asset in spreading the word about EC because their staff have more latitude about what they can discuss.
* School staff often need adolescent-oriented EC materials in many languages.
* School staff need help in identifying affordable, adolescent-friendly providers where they can refer teens for reproductive health care.

At the 2000 EC Jamboree sponsored by the American Society for Emergency Contraception, attendees were asked if they knew of anyone, anywhere in the country, working on EC awareness in schools. The room was silent. Not one person could name a single district or city that had formally integrated information about EC into its health curriculum, counseling, or pregnancy prevention programs.

At the same time, attendees recognized the opportunities that existed within schools. Schools have daily access to many adolescents, their mission is education, and they already offer health education classes, programs, and services. AED and the Harlem Health Promotion Project of the Joseph Mailman School of Public Health of Columbia University had created EC outreach materials for teens (Toolbox-2) and developed and conducted training programs for physicians and pharmacists.[1] With new foundation funding, AED took on the challenge of increasing EC awareness in public high schools in the largest school system in the country. In the 2001-02 school year, New York City had well over 280,000 students attending 228 high schools. While

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most were either academic or vocational, building-based schools, some were schools with multiple off-site programs for older students (e.g., in family care centers, community programs, churches, and vocational centers).

Assessing the Need

The number of teens who become pregnant each year in New York City is close to 30,000. Many teens are in school when they become pregnant, and pregnancy is considered a major factor in the school drop-out rate.[2] Most of these pregnancies are unintended. The New York City school system is well aware of the enormity of this number and of the problems faced by sexually active youth, such as STDs and HIV/AIDS. For over a century, the system has addressed students' health problems with innovative programming. As early as the 1890s, health screenings were introduced in the schools; school nurses eventually replaced physician inspectors, and dental clinics were added to elementary schools in the early part of the twentieth century.[3] In 1984, the first school-based health centers opened in New York City.[4] In 2002, the school system was addressing high pregnancy rates, both through health education and special programs, which became the initial targets for our EC educational outreach (described below).

Gaining Access The New York City school system is huge and complex and therefore difficult to navigate. Some policies relating to sexuality education are centralized, and many decisions regarding implementation of these policies can be made by superintendents of the six districts (which roughly correspond geographically to the city's five boroughs, with a sixth for alternative schools). Principals also exercise considerable discretion over policy implementation. The system is also, like many school systems, highly political when it comes to sexuality education. In fact, several years ago, controversial issues related to sexuality education were inflamed by the press and resulted in the dismissal of the school chancellor. AED was acutely aware that any topic dealing with sexuality had to be handled with care.

For these reasons, we surmised that our EC initiative would progress more swiftly if we were able to obtain the approval of, and cooperation from, the central administration. Our first step was to meet with staff from the office at the New York City Public Schools with responsibility for health education and disease prevention. We had worked with several of these individuals in the past and were granted a meeting immediately. However, they were less than enthusiastic about our plans to train school staff and provide them with EC outreach materials to disseminate to students. They indicated their concern that any EC-related controversy would jeopardize other health education programs, and we were unable to gain overt support for our efforts. They felt more comfortable granting tacit support and directed us to collaborate with TOPPP, a pregnancy prevention initiative with programming in 17 high schools. This was all AED needed to begin reaching out and building a network of adults who were informed about EC in New York's public high schools.

Outreach to Schools

At our first meeting, the TOPPP director asked for EC materials that could be disseminated at an upcoming staff training day. She also suggested we contact the liaisons for health education in every district superintendent's office. Using her name as a reference, we immediately wrote letters to the liaisons (Toolbox -3) to explain our work and offer free materials and training.

As we expected, responses to our letters and phone calls varied. One liaison immediately scheduled a training for assistant principals for health and physical education in her borough, while another scheduled a training only after multiple attempts to reach her over the span of a year. We were startled to encounter a very negative response from a liaison for alternative schools, which generally serve older students. She apparently considered EC an abortifacient and declared it inappropriate for adolescents in her schools for other reasons as well, all of which reflected inaccurate information about EC. She further threatened to complain about us to a member of the Board of Education. Concerned that her actions could jeopardize our efforts, we decided to work with those liaisons who were interested in taking advantage of our assistance and could recommend us to other liaisons. Our post-training evaluation (Toolbox-7) was extremely useful because we were able to use findings to show that other assistant principals considered our training useful and relevant.

Recognizing that a letter of support from the student support services office of the New York City Public

Schools would help us gain access to other groups, we arranged a meeting with a physician who chaired a recently formed health committee for the newly appointed school chancellor. We hoped that our positive experience in two districts would help us make the case for more overt support. We received an enthusiastic reception; however, the physician indicated that, although she was sympathetic, she did not believe EC would be a top priority since the committee was assessing many other important health issues. Nonetheless, this meeting assured us of a well-informed ally within the administration who would be supportive if the topic of EC came up in departmental meetings. As an adviser, this person and her staff later helped us obtain information on review policies pertaining to EC materials that we could relay to training participants.

We moved ahead by developing a list of programs and categories of staff positions within schools that generally have responsibility for pregnancy prevention and health. The list included those in health education and in the prevention of pregnancy, HIV/AIDS, and substance use. Social workers and guidance counselors were also targeted. Where possible, we tried to reach staff in supervisory positions to help ensure that EC information would get passed along every year to new faculty. We also encouraged everyone we trained to spread the word to other key school staff, including any other adults—and most schools have at least one—to whom students turn about a pregnancy scare.

Over the course of two years, and with the help of CBO staff (described below), we provided EC training, informational materials, and technical assistance to school staff working in over 50% of the city's public high schools. These staff included:

* **Assistant principals for health and physical education**
* **Assistant principals for guidance and other guidance counselors**
* **Staff of school-based health centers**
* **Team leaders of school-based HIV/AIDS prevention programs, which provide written materials on many health topics and make free condoms available to students**
* **HIV/AIDS team members and students at a program on HIV/AIDS prevention**
* **Staff of the TOPPP program for pregnant and parenting teens**
* **Prevention and intervention specialists in SPARK, a program to prevent or reduce drug and alcohol use**
* **Staff of the LYFE program, which provides school-based day care for young mothers**

We often conducted EC training at staff meetings or training days, accommodating the length of our training to the time available. We usually had anywhere from 20 minutes to two hours to get our message across, but 60 minutes seemed preferable. (Toolbox-3 contains our PowerPoint presentation. Contact **earcher@aed.org** to obtain the electronic file.) In addition to training, we sent mass mailings to selected school staff with order forms for free EC materials. One school contact invited us to talk to parents about EC at a PTA meeting, and we were invited by the HIV/AIDS prevention program to set up an EC table at a boroughwide program, Parenting in the Age of AIDS.

We conducted a telephone survey with administrators of school-based health centers in high schools to assess their needs for training and EC outreach materials (Toolbox-6). We found that offers of EC materials mailed to the administrators of school-based health centers yielded a low response because their offices are often off-site at a backup health facility. In contrast, all the mid-level health practitioners in school-based health centers whom we contacted directly requested our free informational materials for students.

Frequently, schools asked us to display our EC materials at school health fairs. We felt it would be more effective in the long run to empower a member of the school staff to provide that information, and in many cases, our project data base enabled us to identify a staff person we had already trained within that school. We also offered to work with the coordinators to identify a community-based, health care provider to whom teens could go for EC and follow-up care. We also provided extra supplies of our free EC outreach materials to disseminate at health fairs.

Reaching Out to CBOs That Work with Schools

In New York City, a number of CBOs are welcomed into schools to educate students in a variety of health-risk areas, including unintended pregnancy. We found CBO staff to be more comfortable with sexuality education, less fearful of controversy, and at greater liberty to disseminate materials. We trained:

- **Youth workers of Girls Incorporated of New York City**
- **Teen Choice social workers of Inwood House, an agency serving pregnant and parenting teens**
- **Youth workers in two settlement houses that had just received a grant to do case management for high-risk teens in community schools**
- **Members of the Sexuality Educators Network sponsored by Planned Parenthood of New York City**
- **Youth workers in YMCAs**
- **Staff of the Beacons, afterschool programs for youth in 80 schools in New York City**
- **Staff of programs that are members of Better Bronx for Youth, a boroughwide consortium of youth-serving organizations**

Measuring Success

We have kept close track of the number of adults in schools and CBOs whom we have reached; what we provided (training, EC materials, or TA); their schools and/or districts; and their role in the school. We use a simple data base developed on a spreadsheet. As a result, we know that, as of June 2002, we reached an adult in 54% of New York City public high schools. We reached the highest proportion of schools (95%) in the Bronx high school district (which has the highest teenage pregnancy rates in the city) and the lowest proportion (30%) in the Queens high school district.

After every EC training, we administer an evaluation (Toolbox-7). We have also conducted follow-up telephone interviews to learn 1) whether participants have talked to adults and students about EC and what barriers they have encountered; 2) their comfort in disseminating EC information; and 3) whether they displayed or disseminated the EC materials and what facilitated or obstructed their efforts to do so. Two interviewees discussed the importance of the training:

> *Before the EC training, I discussed other forms of birth control, but not EC because I didn't know about it. Since the training, I use health classes as an opportunity to tell kids about EC along with information about other forms of birth control.* (Physical education teacher)

> *I'm so glad we had the training. Some youth had heard about EC but weren't sure it was real. It was like it was "in the wind." It's important that you are letting us know about EC.* (Guidance counselor)

Another spoke of the importance of teens being informed about EC.

> *In general, contraceptive information is not easily accessible to teens. We need more done on the local level. In the YMCA's we can't give out condoms, and in the schools, they're still giving out the wrong information. Teens should all be well informed.* (YMCA adolescent program director)

We also asked interviewees to suggest ways to improve our training and technical assistance. Of course, we always asked if their supply of EC outreach materials needed replenishing.

If resources were available, AED would like to assess some student outcomes of the project: how many students learned about EC at school; what they learned; and how. We would also like to know how many students subsequently called the EC hotline or visited one of the many websites sites for information, and how many asked their health care providers for EC.

AED has used the evaluation findings for a variety of purposes, including planning next steps, strengthening our program, motivating others to participate in our training, and letting funders know how we are doing.

LESSONS LEARNED ABOUT EMERGENCY CONTRACEPTION AND CBOS

* Unless they are health care providers, CBO staff members were only vaguely aware of EC.
* CBO staff members believe that EC is highly relevant to their work with teens.
* CBOs need free supplies of print materials about EC in multiple languages.
* CBO staff members, particularly those with expertise in pregnancy prevention, have greater comfort levels than school staff in talking to youth about sexuality and protection. They are a welcome resource to school staff.
* CBOs often have greater latitude to discuss EC and disseminate materials in schools than do school staff.
* In addition to classroom teaching, there are multiple opportunities for CBO partnership with schools around EC, including training, health fairs, advocacy, and community service projects.

The history of our involvement with CBOs and EC began in 1997 when AED sought to build EC awareness in Harlem, a Manhattan community with high rates of adolescent pregnancy. In partnership with the Harlem Health Promotion Center and the Adolescent Initiatives Project of the Mailman School of Public Health, Columbia University, we focused on adolescents and their health care providers. A survey of teens attending an adolescent health clinic revealed that less than one-third of those who were sexually experienced had heard of EC, but 87% said that they would consider using it in the future.[5]

We developed a two-pronged approach with regard to CBOs. Working with an advisory committee of CBO staff and adolescents, the project sought to design a public awareness campaign targeting adolescents. Because of the controversial nature of adolescent reproductive health care, project staff found it necessary to meet with community leaders to discuss how EC was perceived in the community, learn of any concerns, and obtain ideas about building community support for strategies to increase EC awareness among adolescents. Encountering some resistance, the project chose to collaborate with a network of providers already convened for a federally funded STD prevention initiative. School of Public Health staff developed and field-tested a model curriculum for peer educators. They also recruited a group of adolescents to work with a graphic designer from the community to design public awareness materials (including flyers, wallet cards, posters, and brochures) (Toolbox-2).

AED provided free training and outreach materials to staff of CBOs already working in the schools on pregnancy prevention. Among the groups we trained were staff who conduct the *Will Power, Won't Power* training for Girls Incorporated of New York City; YMCA youth workers; staff in roles ranging from counselors to physicians at backup health facilities for school-based health centers; Teen Choice social workers from Inwood House (initially a residence for pregnant teens, this is one of the oldest and most respected community agencies working in the schools on pregnancy prevention); and youth workers in settlement houses that had recently received funding to work with high-risk youth in schools. We also trained participants at a meeting of a citywide sexuality education network from public and nonprofit agencies and displayed our materials at a training day for workers from afterschool Beacon programs. A survey of staff who visited our display demonstrated their interest in further training, and we were subsequently invited to conduct an EC workshop to Beacon staff.

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3. DEVELOPING ADOLESCENT-FRIENDLY MATERIALS

When we started our EC project, we could not locate any EC materials designed specifically for adolescents living in low-income neighborhoods, so we decided to design them ourselves. We knew that our materials would be most effective if we involved youth in the design process. Therefore, our partners at the Mailman School of Public Health, Columbia University, conducted five focus groups with 40 teenagers. The groups began with a discussion of contraception in general and then EC specifically. Very few teens knew about EC, and those who were familiar with it had minimal knowledge. For example, they did not know about the time frame for taking the first dose or the way ECPs prevented pregnancy. Both females and males wanted EC information but did not want to ask about it because they were reluctant to admit their lack of knowledge in this area. In general, teens made it clear that they preferred to learn about EC from their peers and from sensitive adults who would treat them as capable decision makers.

We considered the implications of what we had learned from these focus groups. It was clear that ECPs had little product-recognition upon which we could build. Materials needed to be simple since youth wanted to obtain information without necessarily asking an adult. It was important that materials appeal to both girls and boys. Teens in each focus group suggested and discussed possible themes for the materials as well as graphics, colors, format, and content. We also knew that materials needed to be in English and Spanish since a large proportion of the community was Latino. We invited a graphic artist from the community to participate in the focus-group discussions. With input from teens, the artist developed several themes for EC materials that were reviewed by teenagers and project staff. The project decided to launch the materials in pharmacies in the community, in part to build legitimacy for EC. Staff took samples representing each theme to five pharmacists who had previously indicated a willingness to disseminate educational materials. The pharmacists indicated the following:

* **They did not want materials that would generate controversy. Therefore, they preferred designs that would neither depict nor connote sexual situations.**
* **Physical space was in short supply in their pharmacies—that is, they had limited space for posters and brochures. Pharmacists preferred bag stuffers (sheets that could be included with sales of condoms and pregnancy test kits, for example), shelf-talkers (tear-off sheets that could be hung on shelves), and wallet cards.**
* **They requested materials in English and Spanish.**

With approval from the teens, project staff chose a design that would be easily recognizable to today's youth—a beeper (Toolbox-2). A banner reads "Worried about pregnancy after unprotected sex? This message may be for you..." and the beeper displays the message, "Do you know about Emergency Contraceptive Pills?"

When we expanded outreach from Harlem to youth in CBOs and schools throughout the city, we asked the graphic artist to redesign materials using vibrant popular colors and fonts that we thought might be more appealing. We conducted intercept interviews on the streets asking youth whether they preferred the new design or the "beeper" theme. Because half preferred the 'beeper" design, we decided on the more cost-effective choice of reprinting these materials, after adding the names of teen-friendly clinics in each of the city's five boroughs. These materials continue to be popular in schools and CBOs.

ENDNOTES

[1] Funding for this project was provided by the Open Society Institute and the Turner Foundation.

[2] Hotz VJ, McElroy SW, and Sanders SG 1997, The impacts of teenage childbearing on the mothers and the consequences of those impacts for government. In Maynard R ed., *Kids Having Kids: Economic Costs and Social Consequences of Teen Pregnancy*, The Urban Institute Press, Washington, DC: pp. 55-94.

[3] The Center for Reproductive Options, 1986, *School-Based Health Clinics: A Guide to Implementing Programs*, Washington, DC: author.

[4] Welfare Research, Inc. in cooperation with the Office of Research, Evaluation, and Assessment, New York City Board of Education, 1992, *Assessment of New York City High-School-Based Clinics funded by the New York State Department of Health*, Albany, NY: author.

[5] Cohall AT, Dickerson D, Vaughan R, and Cohall R, 1998, Inner-city adolescents' awareness of emergency contraception, *JAMWA 53, Supplement* 2:258-61.

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